

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

14420

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14397

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WASH</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>03</b> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>JACKSON CONVALESCENT HOME</b>		d. STREET ADDRESS <b>1 BROWN AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HARMISON</b> Last <b>ADAMS</b>		4. DATE OF DEATH Month <b>DEC.</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 17, 1893</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BROKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	
11. BIRTHPLACE (State or foreign country) <b>Middleburg, VA.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ROBERT L. ADAMS</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE HARMISON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WVI</b>	
17. INFORMANT <b>JACKSON CONVALESCENT HOME, HAGERSTOWN</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Paralysis agitans.</b> (c) <b>Chronic Cystitis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19, 1960</b> to <b>Dec 6, 1960</b> that (I) (we) last saw the deceased alive on <b>Dec 5, 1960</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE <b>12/9/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman</b>		22d. ADDRESS <b>159 W. Washington St. Hag. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-8-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SHARON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>Middleburg VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>SCOTT F. MINNICH &amp; SON HAGERSTOWN MD</b>		25a. REC'D BY REGISTRAR <b>DEC 8 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>			



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VR AIS (4)  
ISM 9/59

14421

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14398

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>EMMA KATE BENDER</b>				4. DATE OF DEATH Month Day Year <b>December 24 1960</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 13, 1870</b>			
9. AGE (In years lost birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Harry Garlock</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Mace</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>					
17. INFORMANT <b>Mrs. Guy Hoffmaster</b>				Address <b>Hagerstown, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic endarteritis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>year</b> <b>9 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Hagerstown</b>		20h. (State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 2, 1960</b> , to <b>Dec 24, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 23, 1960</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>R. S. Stauffer</b>				22b. DATE SIGNED <b>DEC 29 1960</b>					
22c. PHYSICIAN'S NAME (Type) <b>R. S. STAUFFER</b>				22d. ADDRESS <b>Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>12/27/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			
23d. LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>				23e. (State) <b>Md.</b>		23f. (Country) <b>U.S.A.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Singer</b>				24a. ADDRESS <b>Hagerstown, Maryland</b>		24b. REC'D BY REGISTRAR <b>DEC 29 1960</b>			
24c. REGISTRAR'S SIGNATURE <b>Charles L. K...</b>				24d. DATE <b>DEC 29 1960</b>		24e. (State) <b>Md.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician, must completely fill in pages 2 and 3 and 4 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14422

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14399

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		e. STREET ADDRESS <b>514 North Market Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Mary</b> Last <b>Blair</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 16, 1890</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR: Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Employee (ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Schell</b>		14. MOTHER'S MAIDEN NAME <b>Angela (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-1452</b>	
17. INFORMANT <b>Mr. Joseph H. Blair</b>		Address <b>514 N. Market Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>adenocarcinoma of cervix</b> DUE TO (b) <b>metastasis</b> DUE TO (c) <b>adenocarcinoma of left breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>171X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>adenocarcinoma of left breast</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16, 1960</b> to <b>Dec. 28, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 28, 1960</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Victor L. Ramos, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-31-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert E. Dadey</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the hospital or attending physician, may be issued this certificate for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

## MEDICAL CERTIFICATION

## 14423

1446.0

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hoopital</b>				d. STREET ADDRESS <b>57 W. Franklin St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>		Middle <b>CLARENCE</b>		Last <b>BOWEN</b>	
4. DATE OF DEATH		Month <b>Dec.</b>		Day <b>27,</b>		Year <b>1960</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 1, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Houses etc.</b>		11. BIRTHPLACE (State or foreign country) <b>Luray, Page Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Isaac Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Cave</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-3327</b>		17. INFORMANT <b>Mrs. Bessie Bowen</b> Address <b>57 W. Franklin St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>10/29</b> <b>1955</b> to <b>12/27</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>12/26</b> <b>1960</b> , and that death occurred at <b>3:30</b> A.M. from the causes and on the date stated above. 22a. SIGNATURE <b>George Jennings</b> 22c. PHYSICIAN'S NAME (Type) <b>George Jennings</b> 22b. DATE SIGNED <b>12/27/60</b> 22d. ADDRESS <b>136 W. Washington St., Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 29 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>John E. E. E.</b>			

Wm. G. Wood





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14482

## CERTIFICATE OF DEATH

Item 9 Film 6277 12-27-60 et

14401

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Md.</b> c. LENGTH OF STAY IN 1b <b>95 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Maryland</b> d. STREET ADDRESS <b>122 Fairview Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>(Long)</b> Last <b>Brumback</b>		4. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not Known Approx. 100 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Not Known</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>James Brumback Hancock Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Passive Congestive Heart Failure</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-17 1959</b> to <b>10-16 1960</b> , that (I) (we) last saw the deceased alive on <b>10-16 1960</b> , and that death occurred at <b>4:34 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank B Thomas III M.D.</b>		22b. DATE SIGNED <b>12-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>FRANK B THOMAS III M.D.</b>		22d. ADDRESS <b>HANCOCK, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12.16.60</b>	
23c. NAME OF CEMETERY OR CREMATOR <b>House of Jacobs</b>		23d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. House Hancock Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 19 60</b> DATE	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

(M)

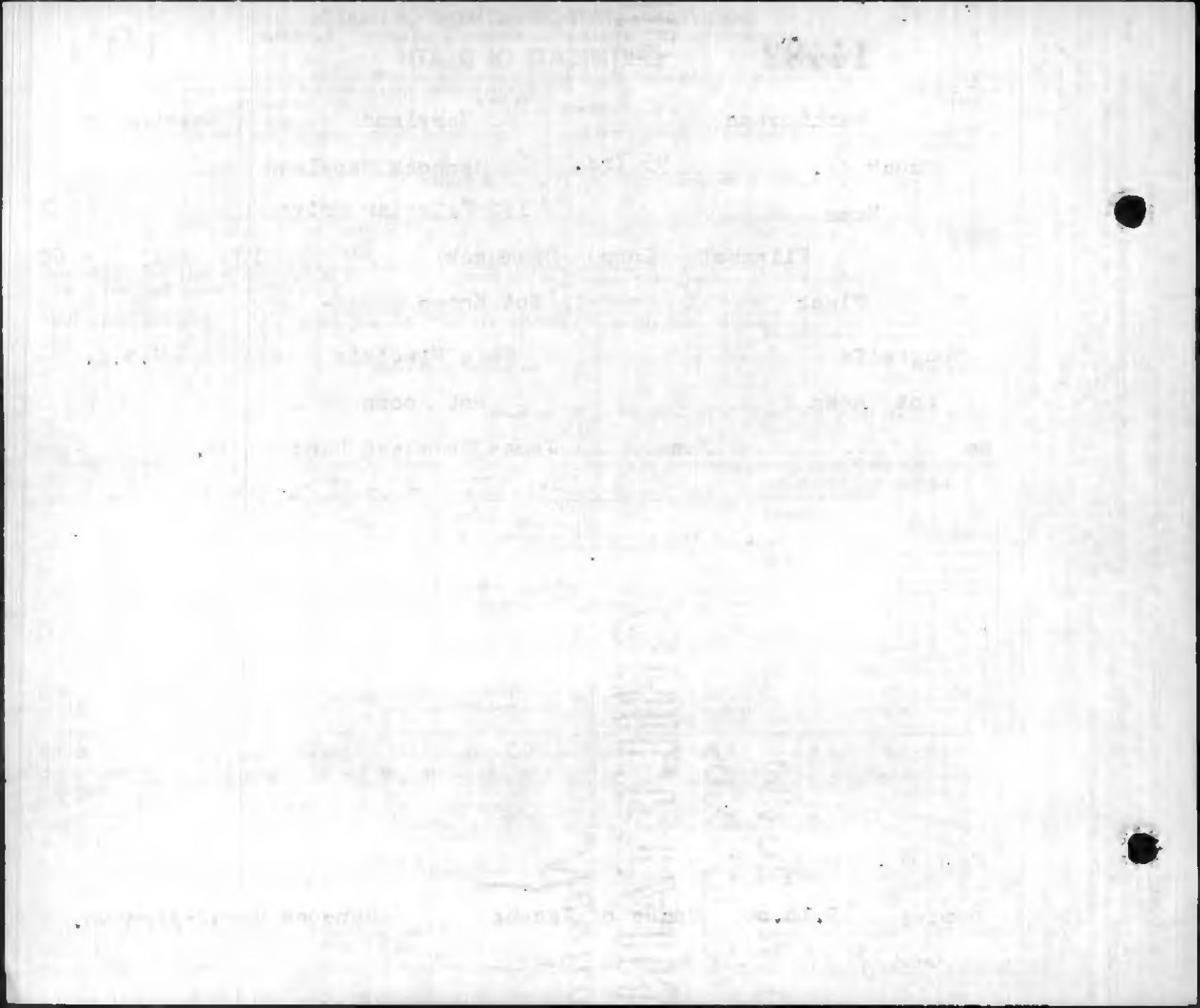
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may be filled in by the attending physician and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14424

14424

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

144' 2

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>18 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1005 Woodland Way</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ford</b> Middle <b>Jerrett</b> Last <b>Bryan</b>				4. DATE OF DEATH Month <b>December</b> Day <b>2</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>July 3, 1907</b>		9 AGE (In years last birthday) <b>53 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stationary</b>		11 BIRTHPLACE (State or foreign country) <b>Centerville Ohio</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Berlington Bryan</b>				14. MOTHER'S MAIDEN NAME <b>Effie Jerrett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO. <b>167-10-4513</b>		17 INFORMANT <b>Mrs. Evelyn A. Bryan</b>		Address <b>Hagerstown, Md.</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>1624</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>metastasis embolus</b> DUE TO (c) <b>Carcinoma of lung</b>							INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>immediate</b> <b>? 8 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>metastasis to Endocardium, adrenals, kidney, liver, neck</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>May 2, 1960</b> to <b>Dec 2, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 2, 1960</b> , and that death occurred at <b>10:17 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. H. Campbell</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. H. Campbell</b>				22d. ADDRESS <b>Hagerstown Md</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-5-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 6 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1.1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

14483 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
14483  
CERTIFICATE OF DEATH 302

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laugansville c. LENGTH OF STAY IN 1b 2 mos d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 6				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laugansville d. STREET ADDRESS Box 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) OLLIE SUSAN BURKER First Middle Last				4. DATE OF DEATH December 14, 1960 Month Day Year			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 3, 1897	
9 AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Luray Paige Co Va		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Luray Paige Co Va	
13. FATHER'S NAME Thomas Lee Burkner				14. MOTHER'S MAIDEN NAME Virginia Breeden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Keller C. Burkner, Box 6 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Aortic aneurysm (c) Diabetes mellitus				INTERVAL BETWEEN ONSET AND DEATH minutes Years Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Laugansville				20g. (County) Washington		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from 11-25-1960 to 11-30-1960, that (I) (we) lost saw the deceased alive on 11-30-1960, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE 12-16-60		22c. PHYSICIAN'S NAME (Type) M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. ADDRESS [Address]				22e. DATE 12-16-60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/17/60		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md				25a. REC'D BY REGISTRAR DATE DEC 19 '60		25b. REGISTRAR'S SIGNATURE [Signature]	





TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14484

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14414

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Smithsburg #2</b>		c. LENGTH OF STAY IN lb <b>52 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Smithsburg #2</b>	
		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) First <b>Preathy</b> Middle <b>Laura</b> Last <b>Carbaugh</b>		4. DATE OF DEATH Month <b>Dec.</b> Day <b>9,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1873</b>
9. AGE (in years lost birthday) <b>87 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Lucas Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Gerald Daywalt</b>		14. MOTHER'S MAIDEN NAME <b>Virginia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. George Codori, Smithsburg Md., #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>422</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 17, 1955</b> to <b>Dec 9, 1960</b> , that (I) (we) lost saw the deceased alive on <b>Dec 9, 1960</b> and that death occurred at <b>2:30</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles F. Hess</b>		22b. DATE SIGNED <b>12/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M. D.</b>		22d. ADDRESS <b>Smithsburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/12/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg</b>		23d. LOCATION (City, town, or county) (State) <b>Smithsburg, Washington Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Walter J. Grove, Waynesboro Pa.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. F. Hess</b>			



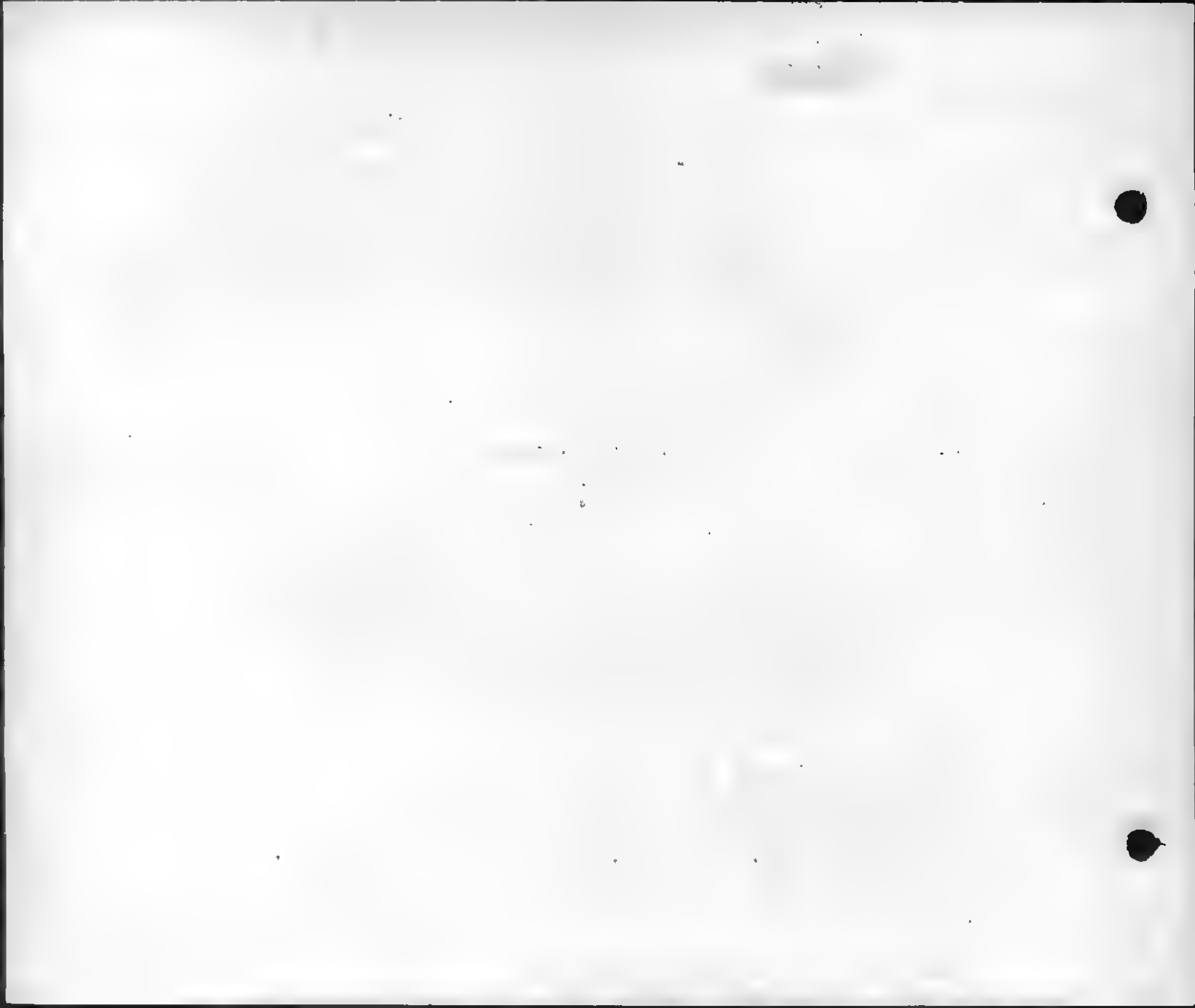
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14425

14425

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		d. STREET ADDRESS <u>1 N. MAIN ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY CATHERINE CASTLE</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 25 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 18 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MYERSVILLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOHN C. STEPLEY</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN CROSNICKLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-16-0075</u>	
17. INFORMANT <u>WAYNE CASTLE</u>		Address <u>BOONSBORO MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>231X</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 Yr (?)</u> <u>5 Yr (?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus - mild.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/21/60</u> to <u>12/25/60</u> , that (I) (we) last saw the deceased alive on <u>12/25</u> 19 <u>60</u> and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Walter H. Shealy</u> M.D.		22b. ADDRESS <u>Sharpsburg, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter H. Shealy M. D.</u>		22d. ADDRESS <u>Sharpsburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>DEC. 28 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Shealy</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

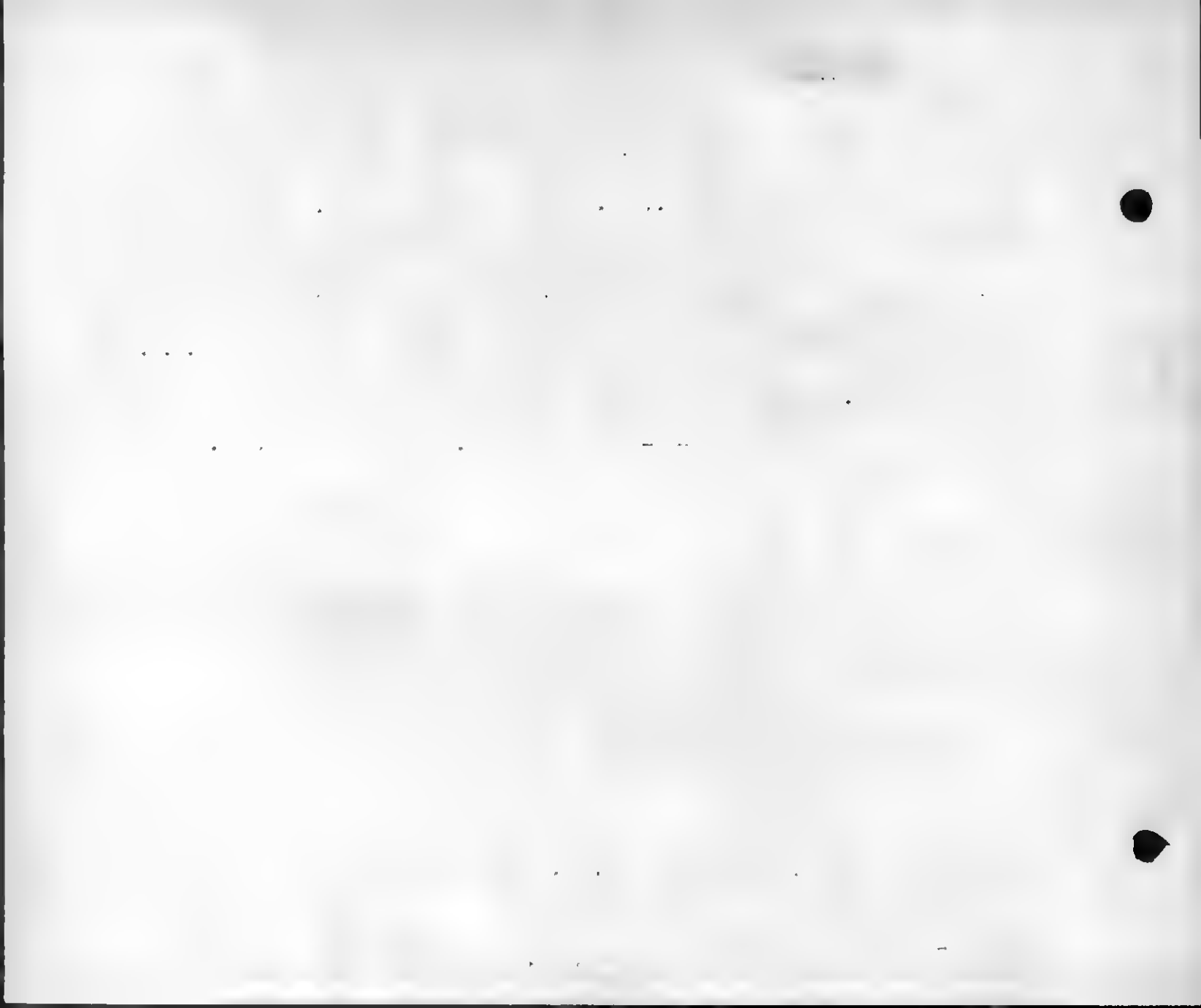
Reg. Dist. No.

14406

14426

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>few minutes</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wilson District, Washington Co., Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>1542 Delray Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RALPH</b> Middle <b>HARVEY</b> Last <b>CLARK</b>				4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1932</b>	
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Body Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Needmore, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harvey A. Clark</b>				14. MOTHER'S MAIDEN NAME <b>Dolly Mc Cullough</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>208-24-1022</b>		17. INFORMANT <b>Harvey A. Clark</b> Address <b>Needmore, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fracture Skull with massive cerebral hemorrhage</b> 819X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple rib fractures @ fracture of hip &amp; ft. shoulder</b> DUE TO (c) <b>thrown from speeding car which went thru guard rail</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>multiple rib fractures @ fracture of hip &amp; ft. shoulder</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>thrown from speeding car which went thru guard rail</b>			
20c. TIME OF INJURY Month, Day, Year <b>Dec 9, 1960</b> Hour <b>11:50</b> a.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19th &amp; 40th St.</b>		20f. (City or town) <b>Hagerstown</b> (County) <b>Wash</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>12/13/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREENWAY CEM.</b>		22d. LOCATION (City, town, or county) <b>BERKELEY SPRINGS, W. VA.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Houzer Funeral Home</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1442 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14417									
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Berkeley</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Martinsburg, (Rural)</b> d. STREET ADDRESS <b>Route # 2</b>				
3. NAME OF DECEASED (Type or print) <b>Roger John Cummings</b>					4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1960</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>Dec. 30, 1943</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>				
11. BIRTHPLACE (State or foreign country) <b>Birmingham, Alabama</b>					12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Austin M. Cummings</b>					14. MOTHER'S MAIDEN NAME <b>Betty Pannebaker</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give order and date of service) <b>NO</b>					16. SOCIAL SECURITY NO <b>NO</b>				
17. INFORMANT <b>Austin M. Cummings, Martinsburg, W. Va.</b>					Address <b>Route # 2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816X</b> DUE TO <b>Basilar Skull fracture</b> Conditions, if any, which gave rise to immediate cause (b) <b>&amp; brain stem injury</b> (c) <b>6 hrs</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Biking in car when auto struck by truck</b>									
20c. TIME OF INJURY Month, Day, Year <b>Dec 3 1960</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At #45 - Martinsburg, W. Va.</b>									
20f. (City or town) (County, (State) <b>Martinsburg, W. Va.</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D.									
EXAMINER'S NAME (Type) <b>Edward W. Ditto 111, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>12-5-1960</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>Hedgesville Cemetery</b>									
22d. LOCATION (City, town, or country) (State) <b>Hedgesville, West Va.</b>									
23. FUNERAL DIRECTOR ADDRESS <b>Howard K. Brown, Martinsburg, W. Va.</b>									
24a. REC'D BY REGISTRAR <b>DEC 7 '60</b>									
24b. REGISTRAR'S SIGNATURE <b>Charles L. Harris</b>									

MEDICAL CERTIFICATION

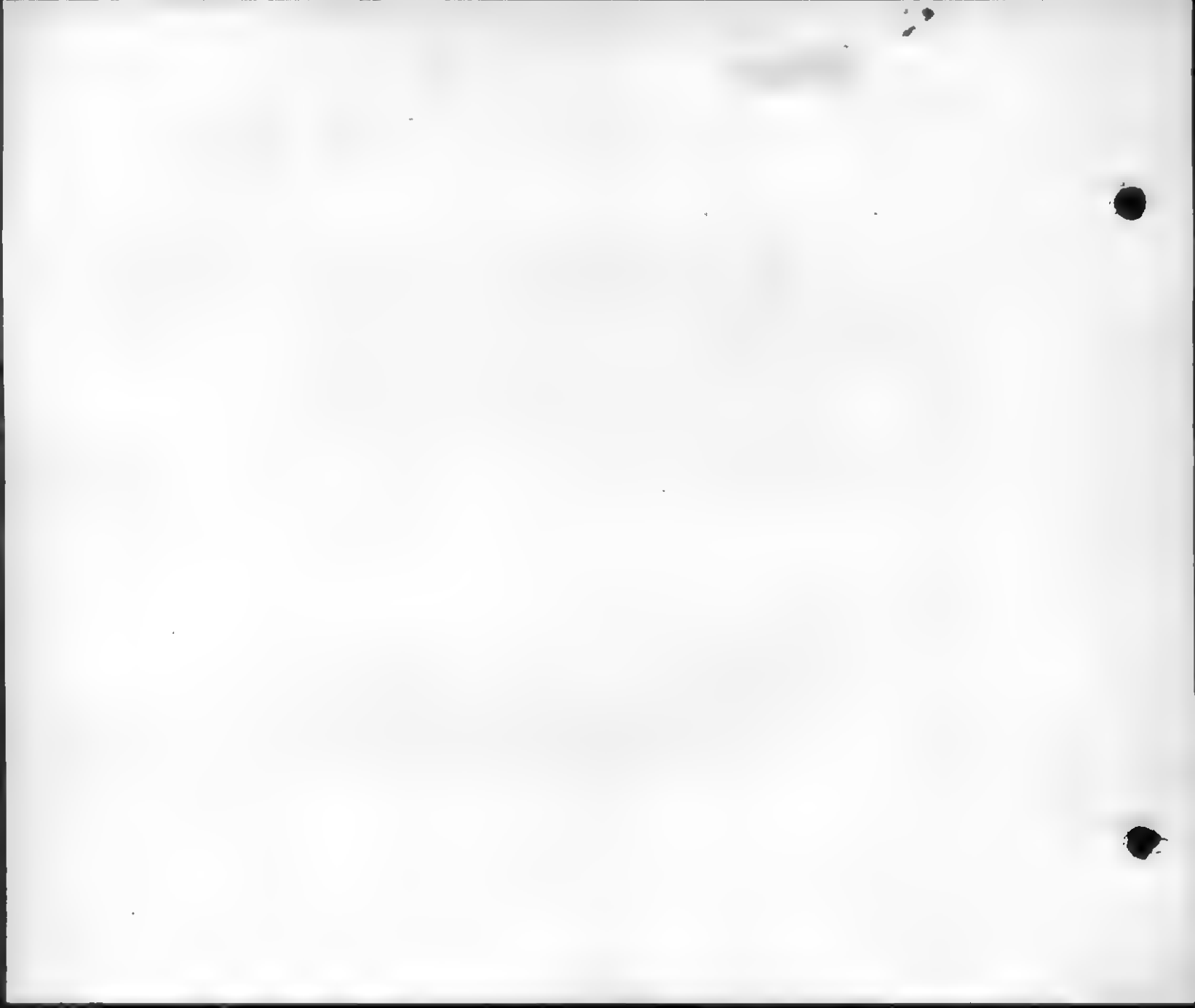
282



## 14428

144-8

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLEAR SPRING</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WESTERN MD. STATE HOSP.</b>				d. STREET ADDRESS <b>MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Annie</b>		Middle <b>Elizabeth</b>		Last <b>CUTSHAW</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1960</b>	
8. DATE OF BIRTH <b>NOV. 28, 1970</b>		9. AGE (in years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months <b>90</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>UNKNOWN</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>DEWEY CUTSHAW</b> Address <b>CLEAR SPRING, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> DUE TO <b>154x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Carcinoma of rectum</b> DUE TO <b>14 months</b> (c) <b>1 month</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease, Pulmonary emphysema</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 31, 1960</b> to <b>Dec. 26, 1960</b> . That (I) (we) last saw the deceased alive on <b>Dec. 26, 1960</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Young E. Chun</b>				22b. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>		22c. DATE SIGNED <b>Dec. 27, 1960</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC. 30, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CLAIRS VALLEY</b>		23d. LOCATION (City, town, or county) (State) <b>CLEAR SPRING, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b> ADDRESS <b>CLEAR SPRING, MD.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14429

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1441

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>MT. BRIER - RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MD. STATE HOSPITAL</u>				d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Herbert H. Dagenhart</u>				4. DATE OF DEATH Month Day Year <u>Dec 29 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 31-1891</u>		9. AGE (In years last birthday) <u>69</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 25</u>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>BOONSBORO WASH. CO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERBERT H. DAGENHART</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA MADDERN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. GOLDIE BENTZ HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 31 1891</u> 19____, to _____ 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above							
22a. SIGNATURE _____				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 29. 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. BRIER CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MT. BRIER WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bentz</u>				25a. REC'D BY REG STRAR <u>AN 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

2. Mr. A. B. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

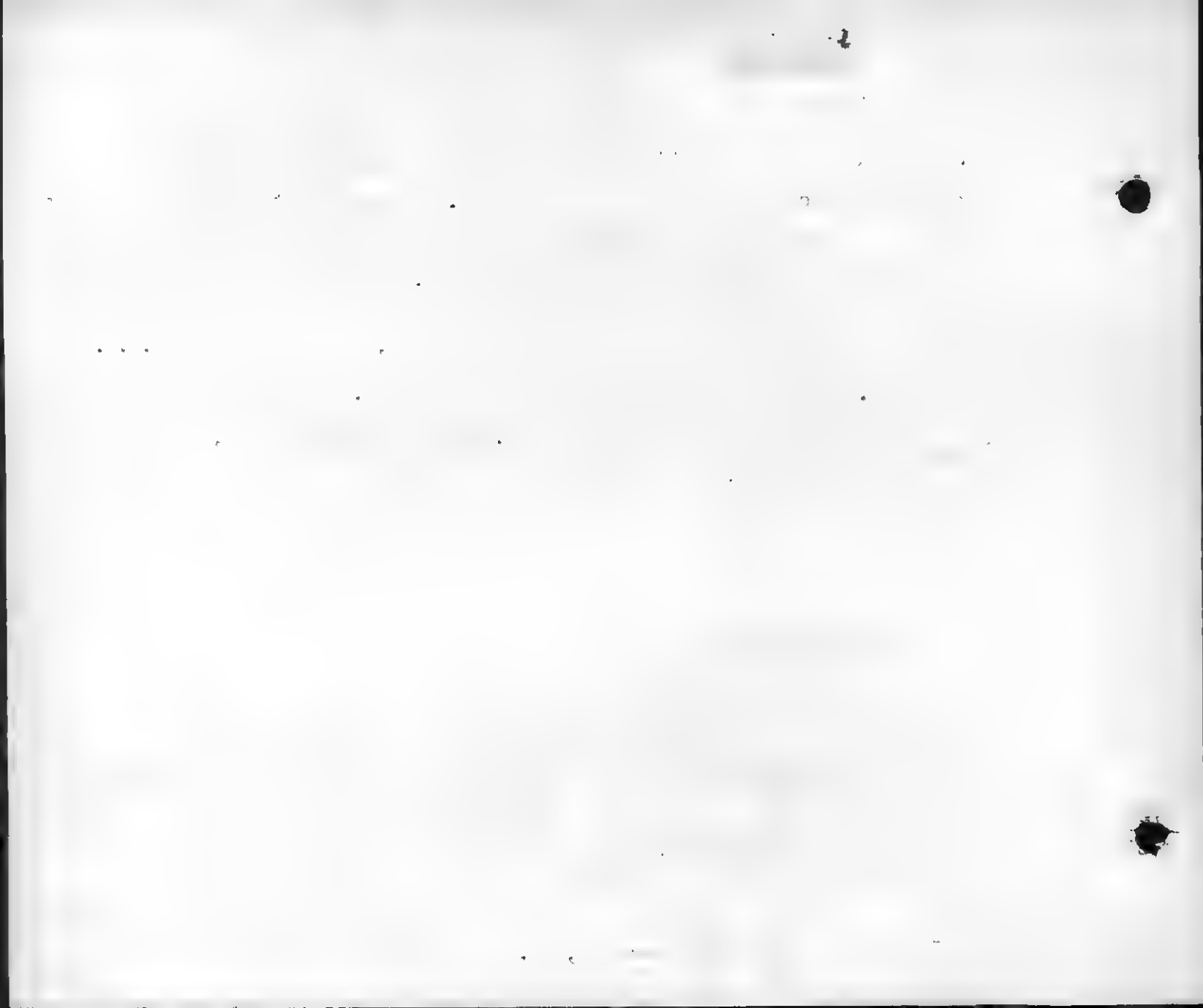
VR A15 (4)  
ISM 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

**14430**

**14410**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convalescent Home</b>				d. STREET ADDRESS <b>1342 N. Potomac Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>CATHERINE</b> Last <b>DAILEY</b>				4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>September 24, 1895</b>	
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>5</b> Hours <b>0</b> Min <b>0</b>		11. IF UNDER 24 HRS: Hours <b>0</b> Min <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry R. Munday</b>				14. MOTHER'S MAIDEN NAME <b>Helen L. Gossard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT Address <b>Roy L. Munday Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of uterus</b> <b>153.8</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug - 30, 1960</b> , to <b>Dec 1, 1960</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>Nov 28, 1960</b> , and that death occurred at <b>1:30 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Lloyd A. Hoffman</b>				22b. DATE <b>12/2/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffman</b>	
22d. ADDRESS <b>214 N. Potomac St.</b>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/3/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. J. S. H. and</b>	
ADDRESS <b>Hagerstown, Md.</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14431

## CERTIFICATE OF DEATH

Reg. Dist. No.

14411

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>	
c. LENGTH OF STAY IN IB <u>2 days</u>		d. STREET ADDRESS <u>49 S. Carlisle St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Houise E. DIETL</u>		4. DATE OF DEATH Month Day Year <u>Dec. 16 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>Antrim Twp., Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>John L. Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Kuhn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>64-30-4421 Mrs Mary Rice - Hagerstown Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Essential Hypertension</u> DUE TO (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1957</u> to <u>Dec 1960</u> that I last saw the deceased alive on <u>16 Dec 1960</u> and that death occurred at <u>3:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. F. Webster</u>		ADDRESS (Street, city or town, state) <u>27 S. Carlisle St Greencastle, Penna</u>	
PHYSICIAN'S NAME (Type) <u>P. F. Webster M. D.</u>		DATE SIGNED <u>12/19/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>12/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich - Greencastle, Pa.</u>		24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>	
ADDRESS <u>Greencastle, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Kline</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14432

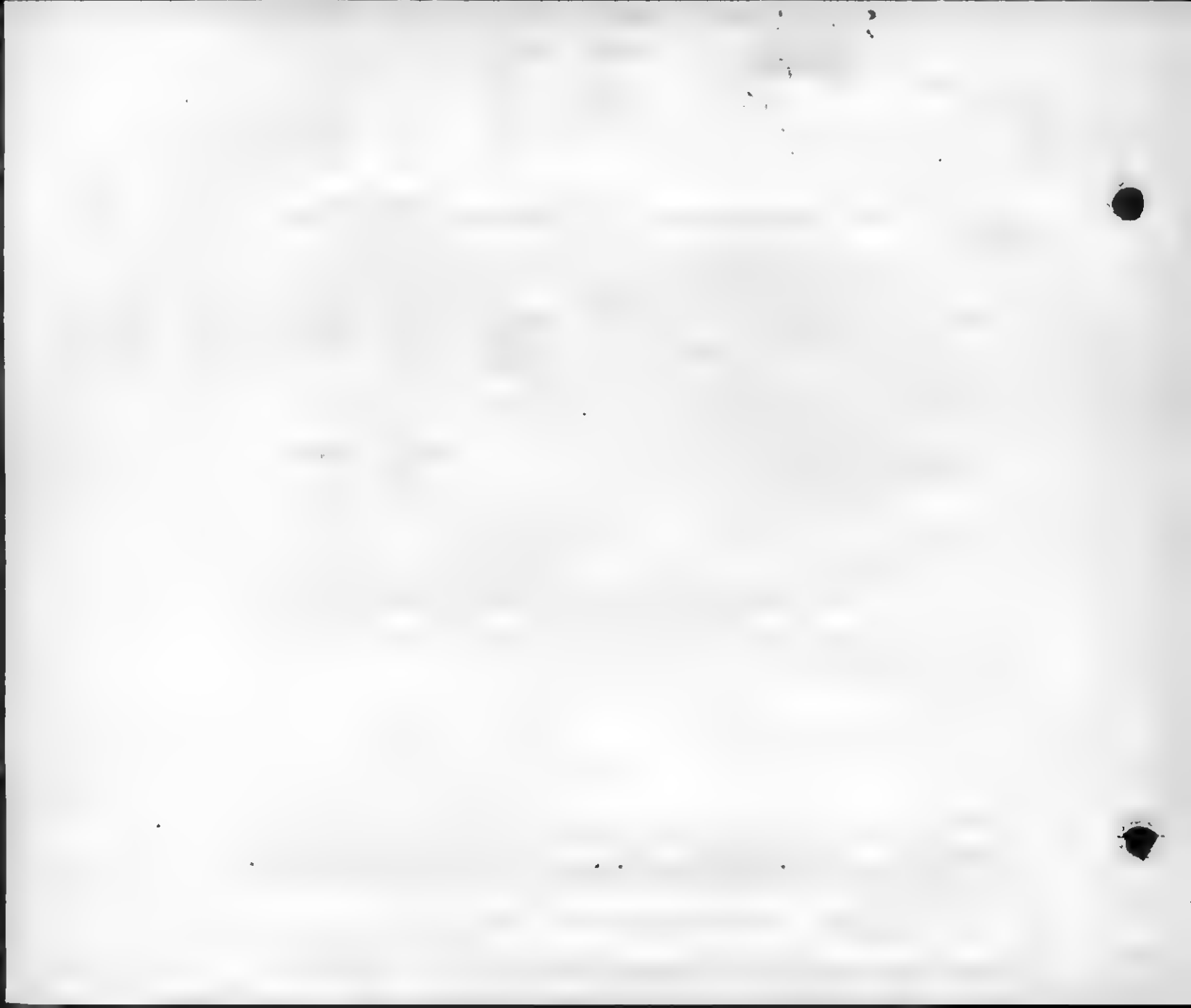
CERTIFICATE OF DEATH

Reg. Dist. No.

14412

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C. Hospital</u>		d. STREET ADDRESS <u>Hagerstown, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>K. L. Bird</u> Middle <u>F.</u> Last <u>Diehl</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/24/1913</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Greensboro, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Leslie Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Mary Fleming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>91-01-3884</u>	
17. INFORMANT <u>Wm. Kent Patching</u>		Address <u>Free care, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute circulatory failure</u> DUE TO (b) <u>Convulsive seizure</u> DUE TO (c) <u>Chronic alcoholism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>? few hours -</u> <u>? 12 hours before death -</u> <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/27, 1960</u> , to <u>12/26, 1960</u> , that I last saw the deceased alive on <u>12/26, 1960</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hornbaker</u> M.D.		ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		DATE SIGNED <u>12/27/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. K. Patching</u>		ADDRESS <u>Hagerstown, Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. K. Patching</u>	

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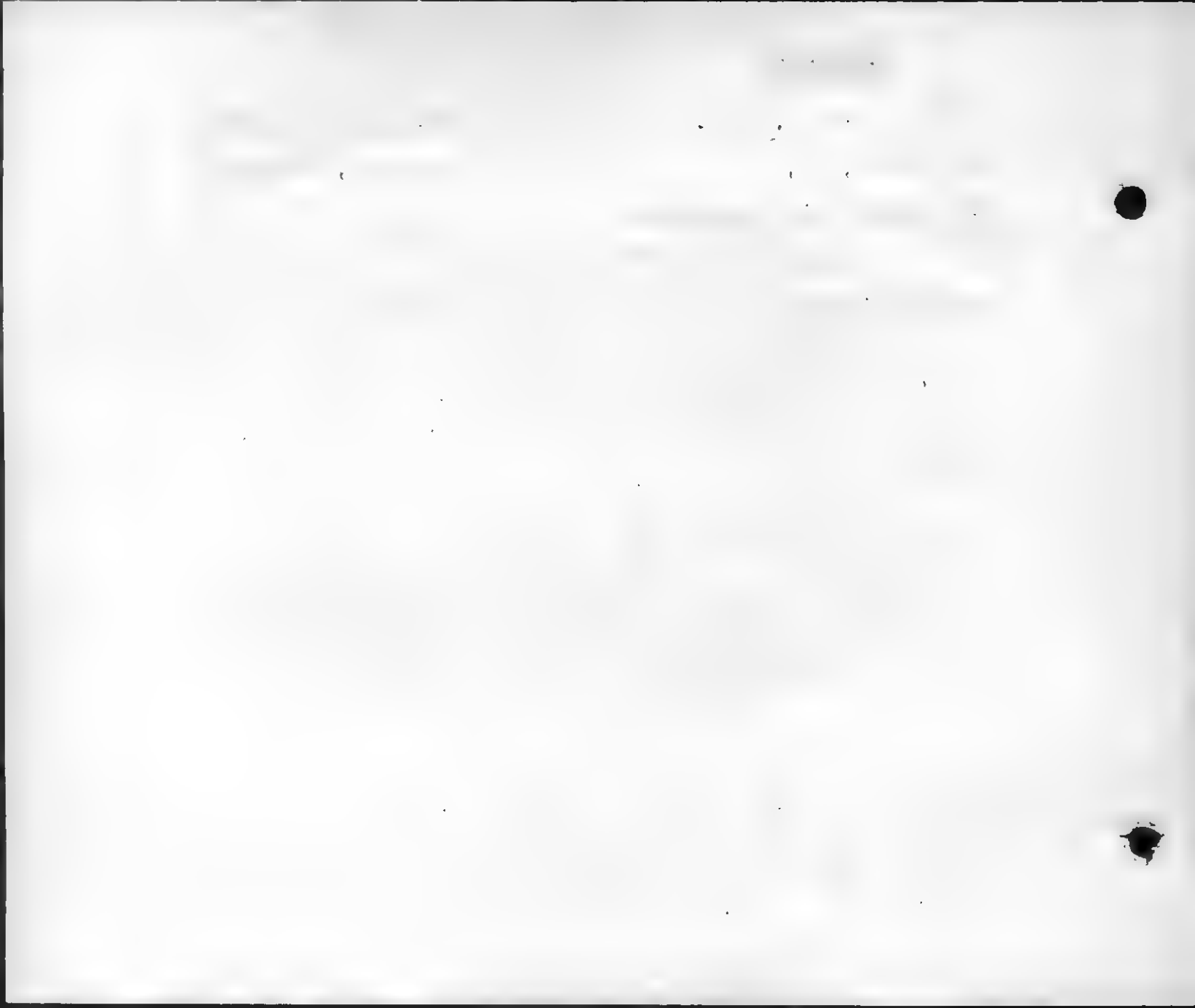
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MEDICAL CERTIFICATION

**HOSPITAL:** [REDACTED] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14414

14485

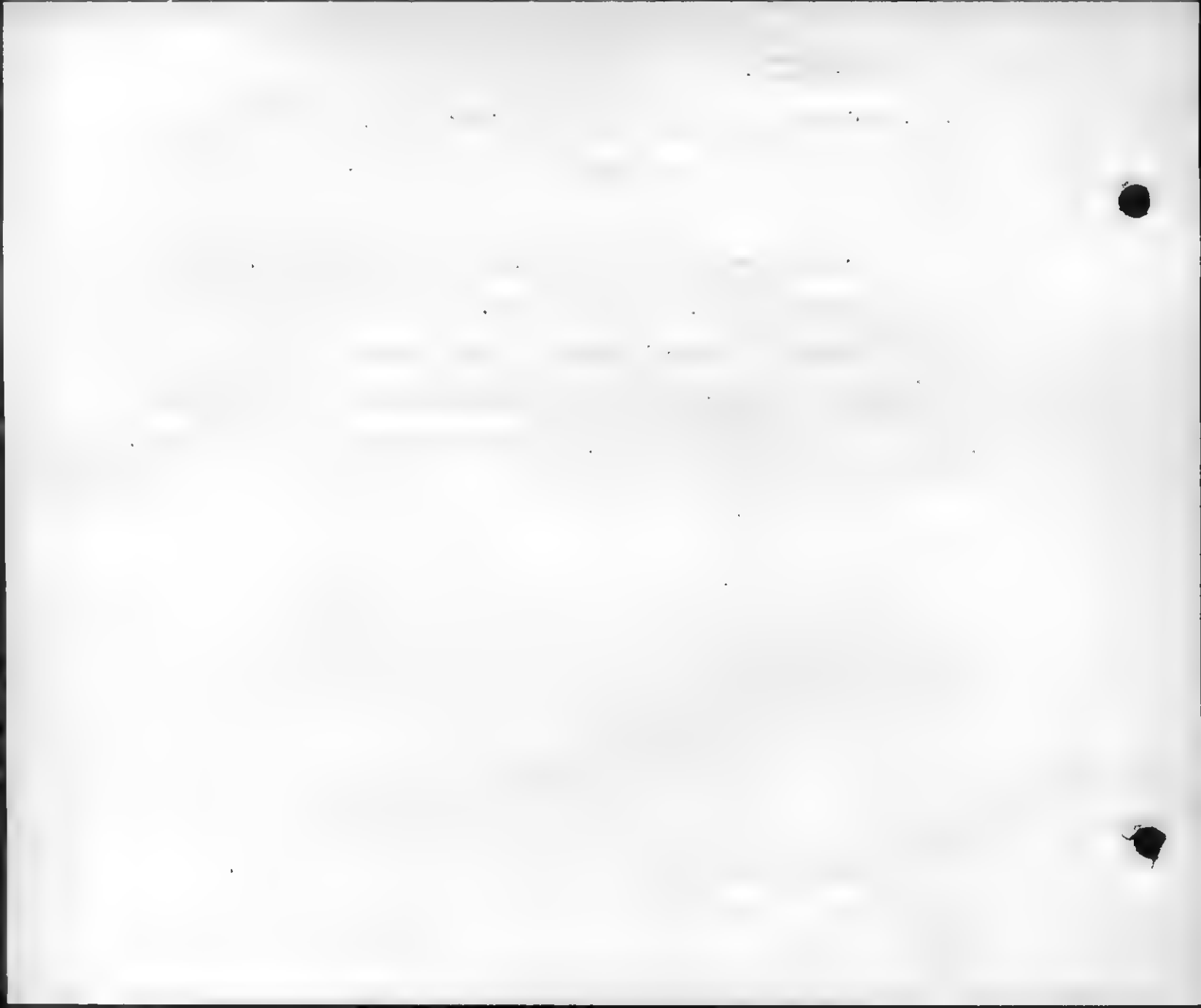
1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BENEVOLE - RURAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BENEVOLE - RURAL</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BOONSBORO MD. R.I.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>TRENTON THOMAS DUBEL</b>				4. DATE OF DEATH Month Day Year <b>DECEMBER - 7 - 1960</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB - 4 - 1881</b>		9. AGE (n years last birthday) <b>79 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min <b>10 3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MOLESVILLE FRED. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>JACOB DUBEL</b>				14. MOTHER'S MAIDEN NAME <b>CHARLOTTE RENNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>220-10-3943</b>		17 INFORMANT <b>LEWIS T. DUBEL</b> Address <b>BOONSBORO MD. R.I.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>450-0</b> DUE TO <b>Conjunctive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Generalized arteriosclerosis -</b> DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>4-28-1959</b> to <b>12-6-1960</b> , that (I) (we) last saw the deceased alive on <b>12-6-1960</b> , and that death occurred at <b>12-6-1960</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph Secondari</b>				22b. DATE SIGNED <b>12/8/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Joseph Secondari</b>	
22d. ADDRESS <b>21 North Main St. Boonsboro, Md.</b>				22e. DATE <b>DEC 13 '60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>DEC. 9, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BENEVOLE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BENEVOLE WASH. CO. MD.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b> ADDRESS <b>BOONSBORO MD.</b>				25a. REC'D BY REG. STR. <b>DEC 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. SECONDARI

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MEDICAL CERTIFICATION



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and to any event within 72 hours after death.

Dr. Hess

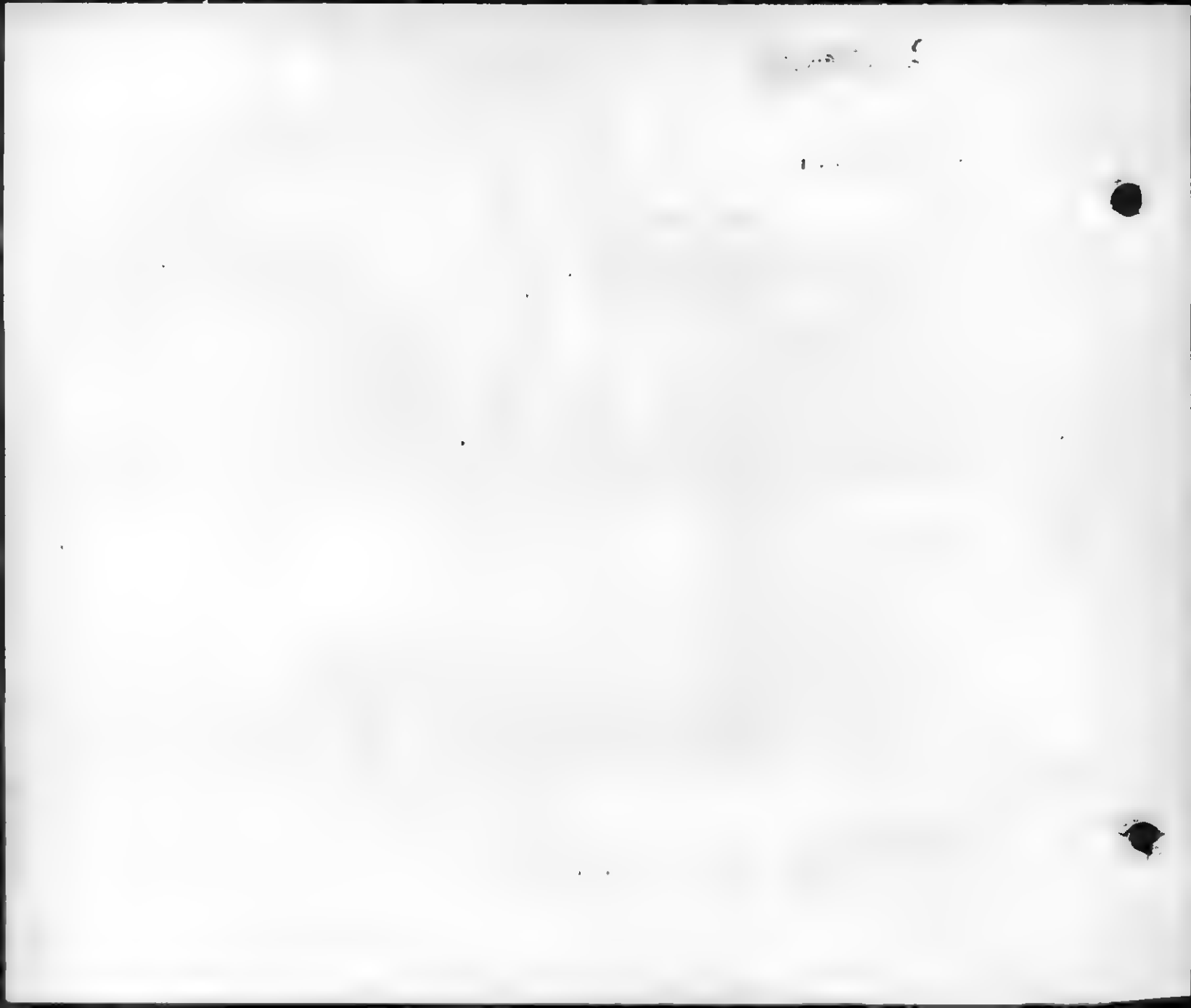
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MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

14415

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. STREET ADDRESS <u>KEEDYSVILLE RD. S.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN LEROY FAYEY</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 22 1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-5-1966</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. CO. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>FRANKLIN LEROY FAYEY SR.</u>				14. MOTHER'S MAIDEN NAME <u>LENA COLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FRANKLIN L. FAYEY</u> Address <u>KEEDYSVILLE RD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastroenteritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nutritional deficiency</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Earl, Trauma</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> to <u>12/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/22</u> 19 <u>66</u> , and that death occurred at <u>0110</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Charles F. Hess M.D.</u>				22b. ADDRESS <u>311 N. ...</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>				22d. DATE SIGNED <u>12/27/66</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>DEC 31 1966</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>KINGCOLD CEMETERY</u>				23d. LOCATION (City, town, or county) (State) <u>KINGCOLD WASH. CO. MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>James E. ...</u>				25a. REC'D BY REGISTRAR <u>Boonsboro</u>			
25b. REGISTRAR'S SIGNATURE <u>James E. ...</u>				DATE <u>12/27/66</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14435

14416

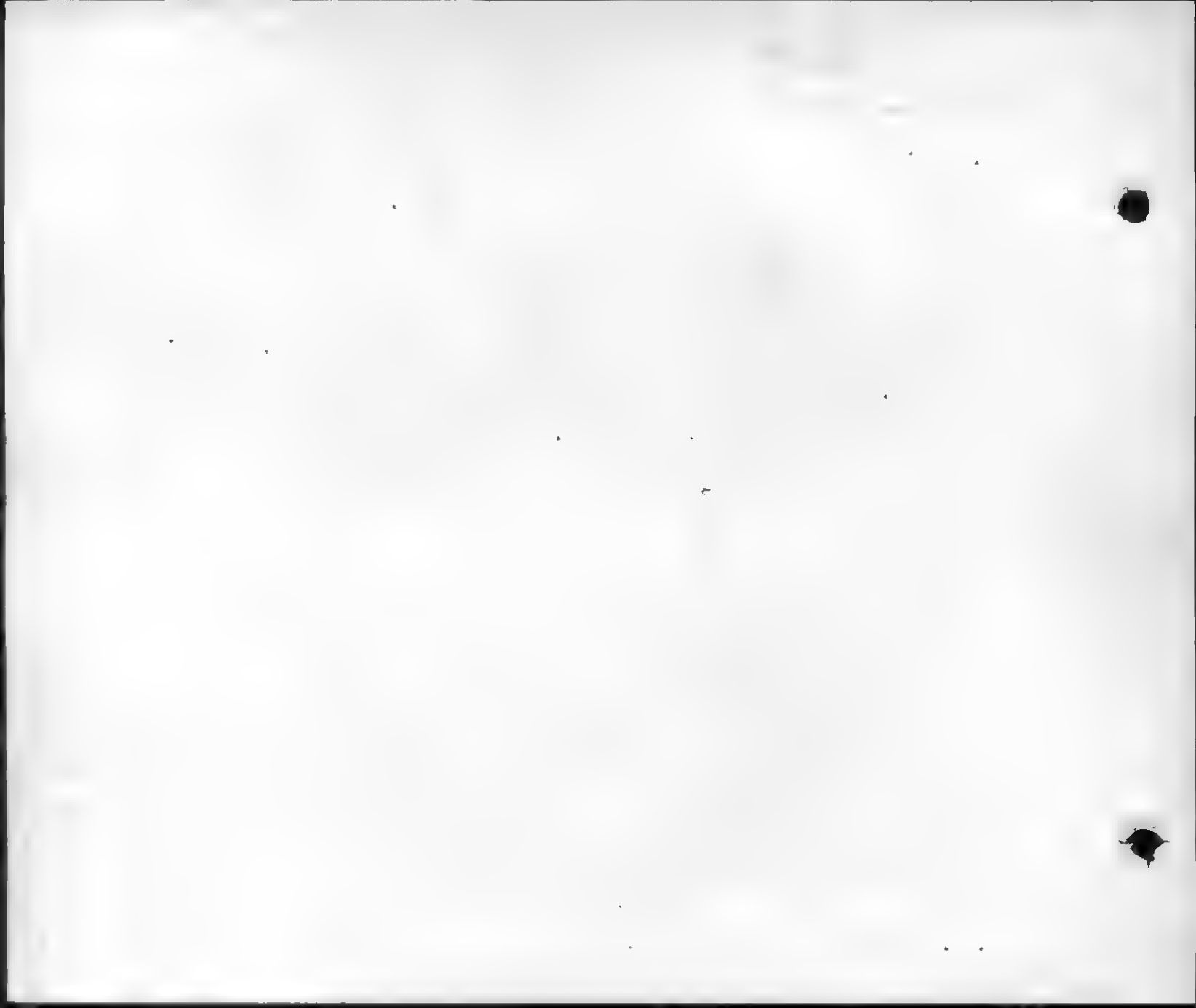
1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN lb <b>Since 5/9/60</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS <b>120 E. 8th Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA McMICHAEL EDWARDS</b>				4. DATE OF DEATH Month Day Year <b>DEC 17 1960</b>			
5 SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 March 1912</b>	
9 AGE (in years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Minister of the Gospel Philadelphia, Pa.</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William E. Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Callan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>427-34-8473</b>		17. INFORMANT Address <b>W. Raymond Edwards (Same as item #2)</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>CARCINOMATOSIS ABDOMINAL</b> DUE TO (c) <b>CARCINOMA OF OVARY</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>19 months</b> <b>20 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 9</b> , 19 <b>50</b> , to <b>DEC 17</b> , 19 <b>50</b> , that (I) (we) last saw the deceased alive on <b>DEC 17</b> , 19 <b>60</b> , and that death occurred at <b>7:55</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Antonio U. Pallacrosi</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>17 Dec 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLACROSI</b>				22d. ADDRESS <b>WESTERN MD. STATE HOSPITAL - HAGERSTOWN Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick County Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR <b>DEC 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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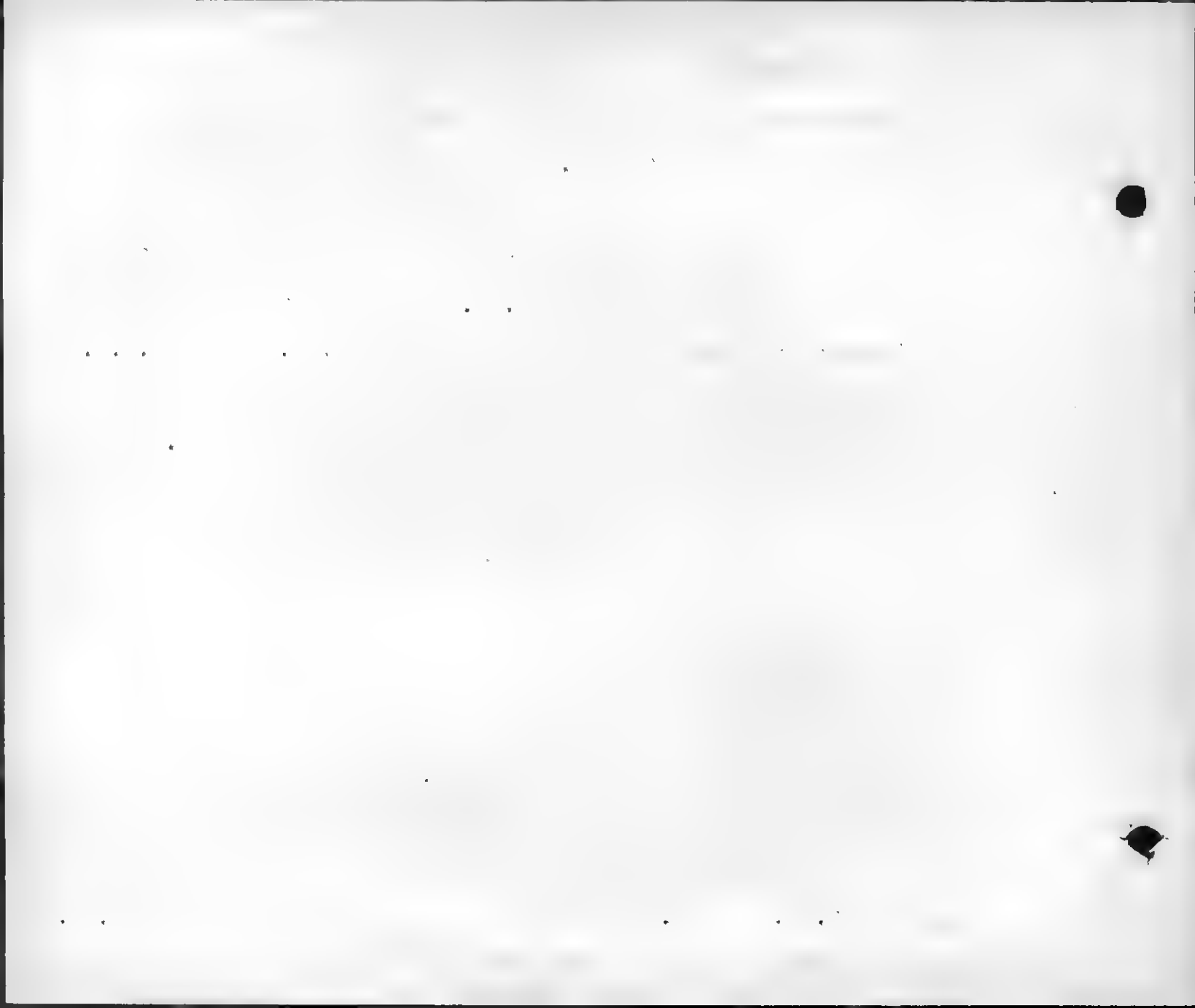
VR AIS (4)  
15M 9/59

14486

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14417

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairview Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		d. STREET ADDRESS <b>Hancock Maryland</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Edith</b> Last <b>Effland</b>		4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9.24.1898</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR: Months <b>62</b> Days <b>23</b> Hours <b>12</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Great Capon W.VA.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John L. Dowson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Charles F. Effland Hancock Md.</b>	
17. INFORMANT <b>Charles F. Effland Hancock Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Congestive heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Diabetes Mellitis and Chronic Nephrosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>6 yrs</b> <b>20 yrs</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 24 1928</b> to <b>12-23 1960</b> that (I) (we) last saw the deceased alive on <b>12-23 1960</b> , and that death occurred at <b>5:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank B. Thomas III M.D.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>12-24-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frank B. Thomas III M.D. Hancock, Md.</b>			
22d. ADDRESS			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>12.26.60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Nebo Cemetery</b>			
23d. LOCATION (City, town, or county) (State) <b>Great Capon Morgan W.VA.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard J. Stone Hancock Md</b>			
25a. REC'D BY REGISTRAR <b>DEC 28 '60</b> DATE			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Stone</b>			





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14418

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route #6</u>				d. STREET ADDRESS <u>1 Route #6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Laban</u> Middle <u>L. Eshleman</u> Last <u></u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 20, 1897</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 MRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co. Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Christian H. Eshleman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lesher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-7802</u>		17. INFORMANT <u>Mr. Anna L. Eshleman</u> Address <u>Rt 6 Hagerstown Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient was shoveling snow at his home when suddenly taken ill.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Paradise Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arnold H. Zimmerman</u>				24a. RECEIVED BY REGISTRAR <u>DEC 28 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. H.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in the envelope, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14436

CERTIFICATE OF DEATH

14413

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 20 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 613 Ravenswood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle KATHERINE Last FEARNOW		4. DATE OF DEATH Month Dec. Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1915
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolteacher		10b. KIND OF BUSINESS OR INDUSTRY Education	
11. BIRTHPLACE (State or foreign country) Salem, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gold W. White		14. MOTHER'S MAIDEN NAME Katherine McAllister	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 154-07-5862	
17. INFORMANT Address Hagerstown, Md. Mr. Clarence Fearnow 613 Ravenswood Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Lymphoma to Sternum, Lungs, Abdominal Viscera 200.2 DUE TO (b) Malignant Retroperitoneal lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 months 8 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (XXXXXX) attended the deceased from May 1960 to Dec. 23, 1960, that (I) (X) last saw the deceased alive on Dec. 23, 1960 and that death occurred at 7:45 pm, from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman, M.D.		22b. DATE SIGNED 12-24-60	
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 27 '60	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hunter	

Wm. G. Hox +



TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

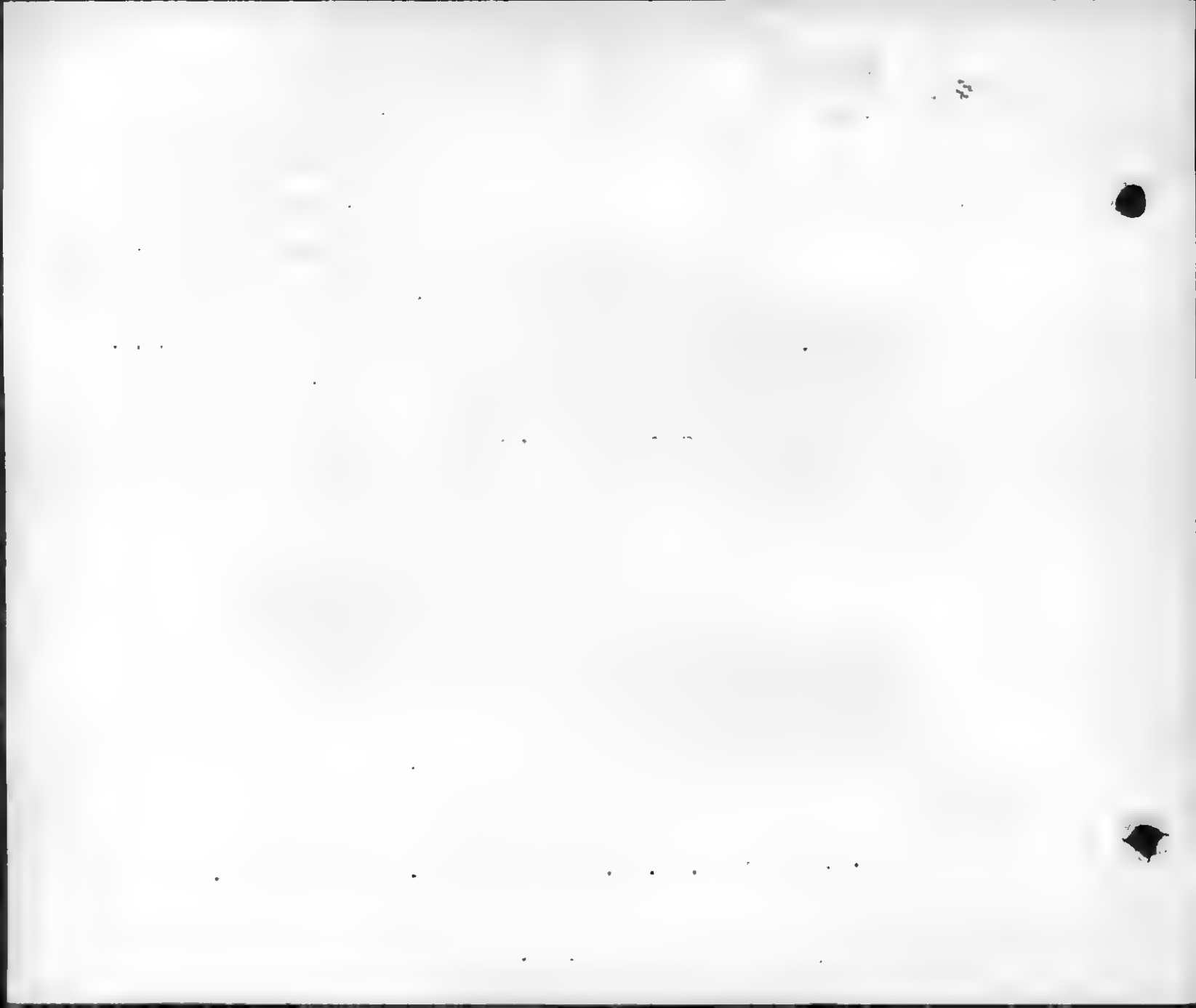
VR AIS (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14420

14437

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>15 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1120 Carroll Hights Boulevard</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Hagerstown, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>EDWARD</b> Last <b>FINK</b>				4. DATE OF DEATH Month <b>December</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 2, 1915</b>		9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Field Service Rep.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Company</b>		11. BIRTHPLACE (State or foreign country) <b>Buffalo, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward George Fink</b>				14. MOTHER'S MAIDEN NAME <b>Borghild Gjersvig</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>071-07-0396</b>		17. INFORMANT <b>Mrs. Dollymae Fink</b> Address <b>Hagerstown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO (b) <b>Acute Coronary occlusion</b> DUE TO (c) <b>Coronary atherosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>4 hours</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 2, 1957</b> to <b>Dec 17, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 17, 1960</b> , and that death occurred at <b>12:00 Noon</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>L. L. Packer Jr.</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. L. Packer Jr., M. D.</b>				22d. ADDRESS <b>145 W. Washington St.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>12/20/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Buffalo, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Franklin Suter</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 21 1960</b> DATE	
				25b. REGISTRAR'S SIGNATURE <b>Carl A. Evans</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

14438

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 303

14421

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>7 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>36 Nottingham Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CATHERINE HOLSBERRY GRIFFETH</b>				4. DATE OF DEATH Month Day Year <b>December 6 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 18 1862</b>	
9. AGE (In years last birthday) <b>98</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <b>Philippi Barber Co W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>Isaac Holsberry</b>				14. MOTHER'S MAIDEN NAME <b>Matilda (no record)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT Address <b>Lrs Ersa Whipp 132 So Locust St</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Cardiac Arrest</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic heart disease</b> DUE TO (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 yrs</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) <b>None</b>				20g. (County) <b>None</b>		20h. (State) <b>None</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>May 13, 1960</b> to <b>Dec. 6, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 6, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John D. Turco</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-7-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. John D. Turco</b>				22d. ADDRESS <b>302 N. Potomac Street-Hagerstown, Md</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Philippi Fraternal Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Philippi Barber Co W.Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Andrew K. Coffman Hagerstown Md</b>				25a. REC'D BY REGISTRAR <b>DEC 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. House</b>	

MEDICAL CERTIFICATION





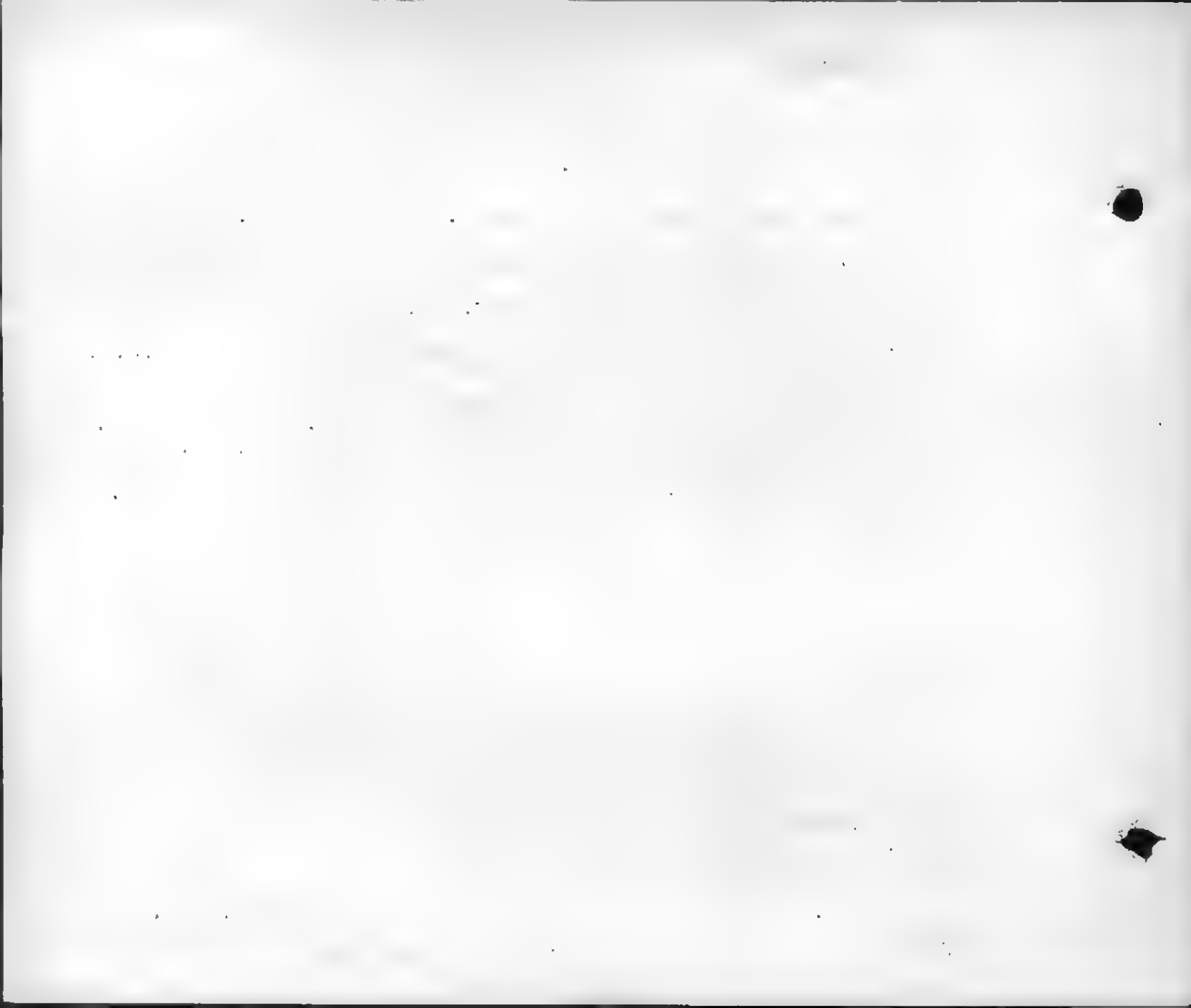
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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14439  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14422

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>25 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>755 West Washington Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence May Grooms</u>		4. DATE OF DEATH <u>December 18 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 18, 1872</u>
9. AGE (In years last birthday) <u>88</u> yrs.		F UNDER 1 YEAR <u>3</u> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Banzhoff</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Null</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Susan Grove</u>		Address <u>755 W. Washington St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> 19 <u>60</u> to <u>18 Dec</u> 19 <u>60</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>16 Dec</u> 19 <u>60</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>F. F. Lusby</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>		22d. ADDRESS <u>2301 Potomac St Hagerstown Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 20, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or County) (State) <u>Williamsport, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Ziegler Williamsport, Md</u>		25a. REC'D BY REGISTRAR <u>DEC 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

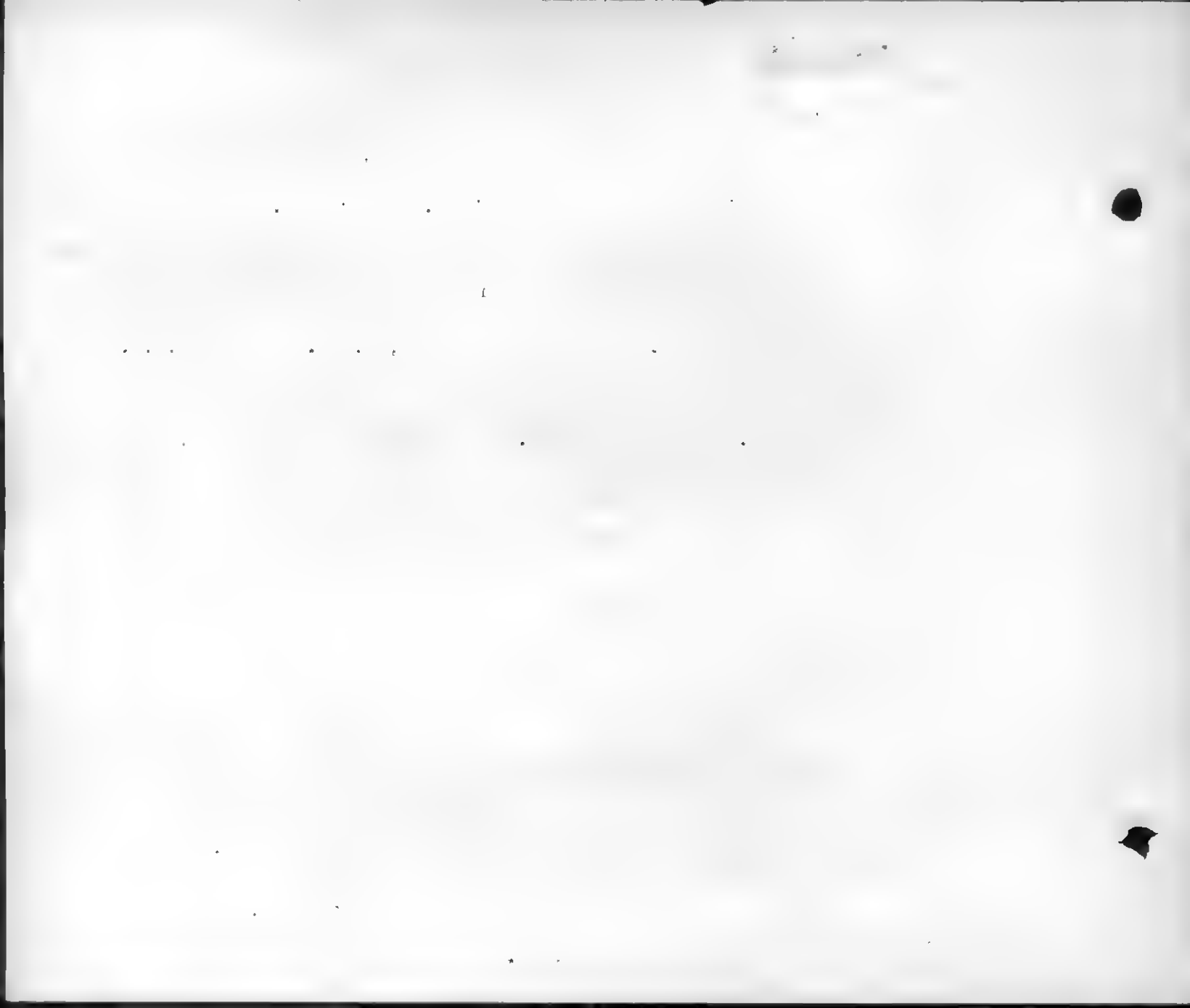
14440

CERTIFICATE OF DEATH

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

14423

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>66 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>323 W. Wilson Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>FRANCIS</b> Last <b>HAMILL</b>		4 DATE OF DEATH Month <b>December</b> Day <b>16</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>October 9, 1880</b>
9 AGE (In years last b'rthday) <b>80</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Policeman</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>City of Hagerstown</b>		11. BIRTHPLACE (State or foreign country) <b>Piedmont, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>Spanish-Amer.</b>		17. INFORMANT <b>Mrs. Virginia Sites</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of prostate</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>11/23/59</b> to <b>12/16</b> , 1960, that (I) (we) last saw the deceased alive on <b>12/15</b> , 1960, and that death occurred at <b>2:30</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>George Jennings</b>		22b. DATE SIGNED <b>12/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Jennings</b>		22d. ADDRESS <b>1364 Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/19/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 21 1960</b>	
25b. REGISTRAR'S SIGNATURE <b>C. W. S. Rouzer</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

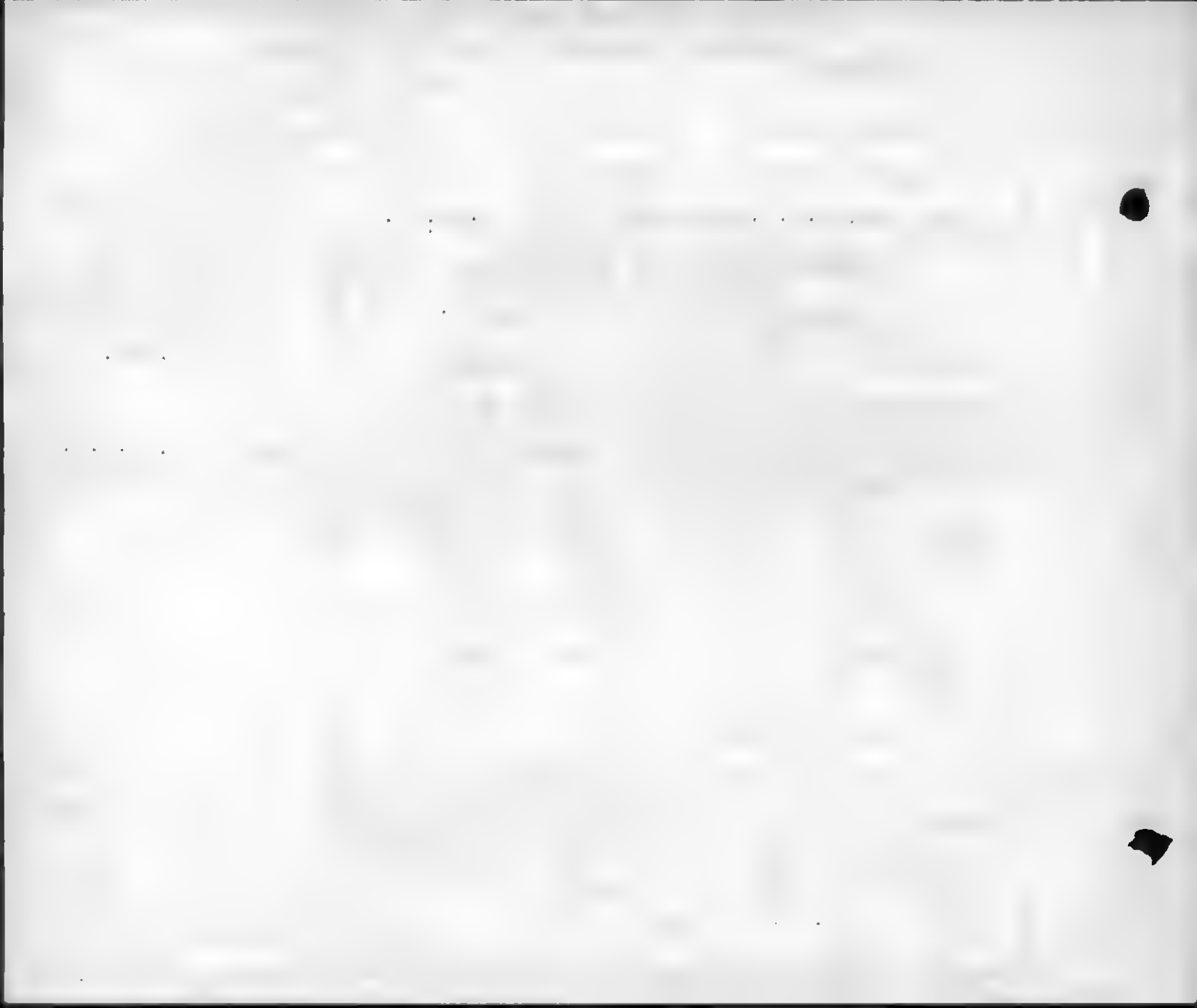
14424

14488

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Coseytown Road</u> c. LENGTH OF STAY IN 1b <u>14 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hagerstown, R.F.D. #1</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u> d. STREET ADDRESS <u>R. F. D. #4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alfred</u> First <u>Henson</u> Middle <u>Henson</u> Last		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 11, 1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>4</u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tenant farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Pinesburg, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Henson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Amanda Henson Hagerstown, Md. R.F.D. #4</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u> <u>10 yrs</u> <u>10 yrs</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 18, '60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Williamsport, Maryland</u>		22e. (State) <u></u>		22f. (Country) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. H.</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



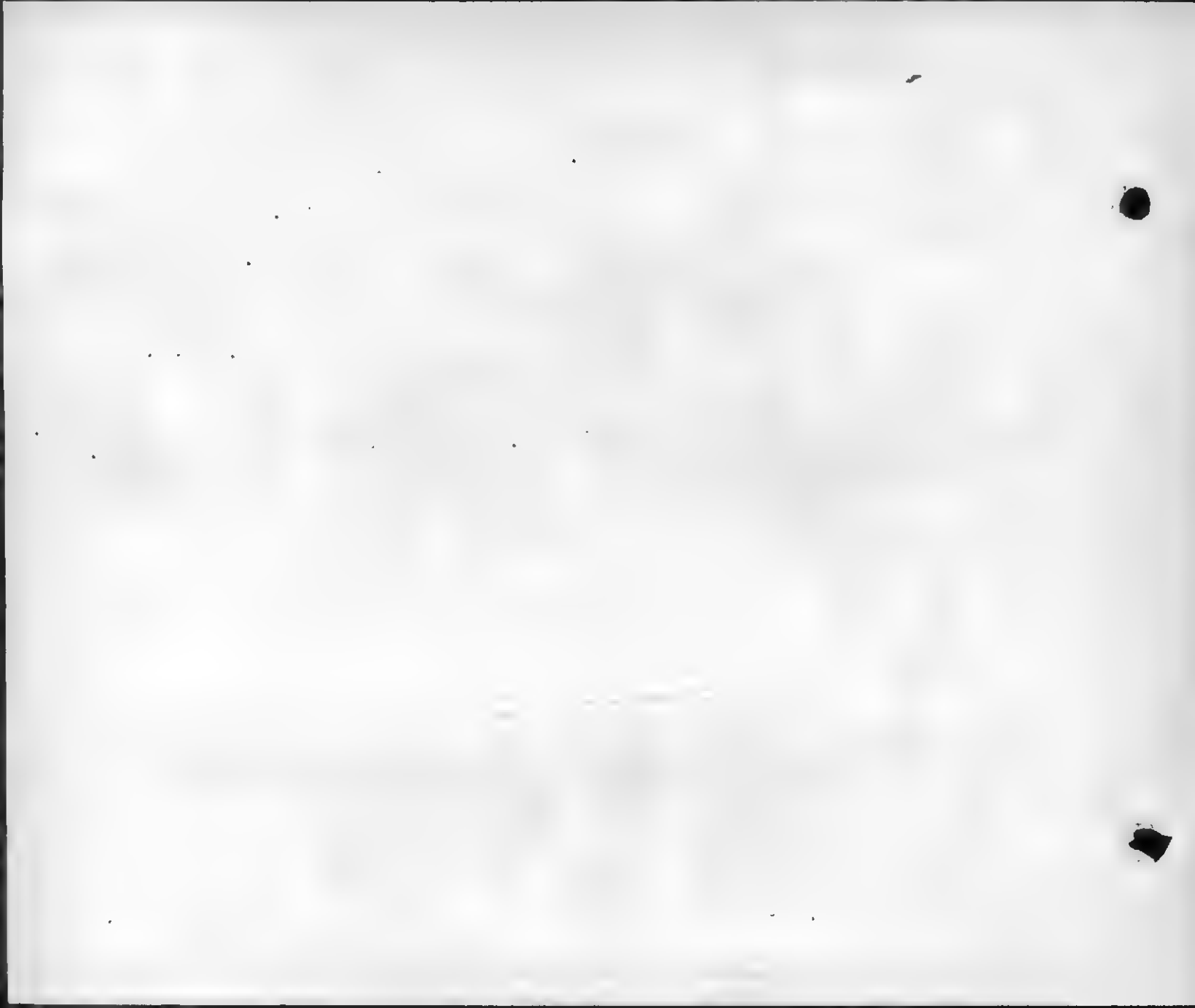
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **1425**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Halfway (Esso Station)</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1910 Virginia Ave.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Guy Robert Hessong</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Dec. 5 19 60</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>July 4 1879</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Labor</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tannery</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>near Greencastle Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>(unknown) Hessong</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>214 10 2181</u>		<b>17. INFORMANT</b> <u>Mrs. Sadie Hessong</u> <u>1910 Virginia Ave. Hagerstown Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Striking</u> <u>451 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Emergency</u> (c), stating the underlying cause last. DUE TO <u>Posterior</u> (c)								INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>[Signature]</u> M.D.					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DATE SIGNED</b> <u>12/6/60</u>	
<b>EXAMINER'S NAME</b> (Type) <u>W. E. W. D. T. T. T.</u>					<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>Dec. 8-60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Manor Cemetery</u>			<b>22d. LOCATION</b> (City, town, or county) (State) <u>Near Tilghmanton Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <u>Albert Leaf Williamsport, Md</u>					<b>24a. REC'D BY REGISTRAR</b> <u>DATE DEC 7 1960</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14489

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14426

## CERTIFICATE OF DEATH

Item 7-111m0277 12-21-60 et

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conococheague		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersville	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Grover F. Horine		4. DATE OF DEATH Month 12 Day 7 Year 1960	
5 SEX male	6. COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/1889
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner		10b. KIND OF BUSINESS OR INDUSTRY farm	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joshua D. Horine		14. MOTHER'S MAIDEN NAME Alice Schildknecht	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 215-36-6718	
17. INFORMANT Mrs. Annie Horine, Myersville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 Carcinoma of Bowel DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 5, 1960 to Dec 7, 1960 that (I) (we) last saw the deceased alive on Dec 6, 1960 and that death occurred at 5:30 PM from the causes and on the date stated above			
22a. SIGNATURE David R. Brewer M.D.		22b. DATE SIGNED 12/7/60	
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/9/1960	
23c. NAME OF CEMETERY OR CREMATORY U.B. Cemetery		23d. LOCATION (City, town, or county) (State) Myersville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE gladhill Company, Middletown, Md.		ADDRESS	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE DEC 12 '60			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician only, completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

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14490  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14427

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Hagerstown RQ4</u>		e. STREET ADDRESS <u>Hagerstown RQ4</u> <input type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MARY HORST</u>		4. DATE OF DEATH Month Day Year <u>Dec 2 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/13/1897</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. Co., md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Amos M. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Horst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Amos E. Horst - Clearspring, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yrs.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2 1960</u> to <u>Dec 2 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 2 1960</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>B. B. Kneisley</u> M.D.		22b. DATE SIGNED <u>Dec 2 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. KNEISLEY</u>		22d. ADDRESS <u>148 W. Washington St. Hagerstown Md.</u>	
23a. MORTALITY, CREMATION, REMOVAL (Specify) <u>B.</u>	23b. DATE THEREOF <u>12/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clearspring Cem. Clearspring, Md.</u>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Mennich - Greencastle, Pa.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>DEC 6 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Caroline E. Kneisley</u>	



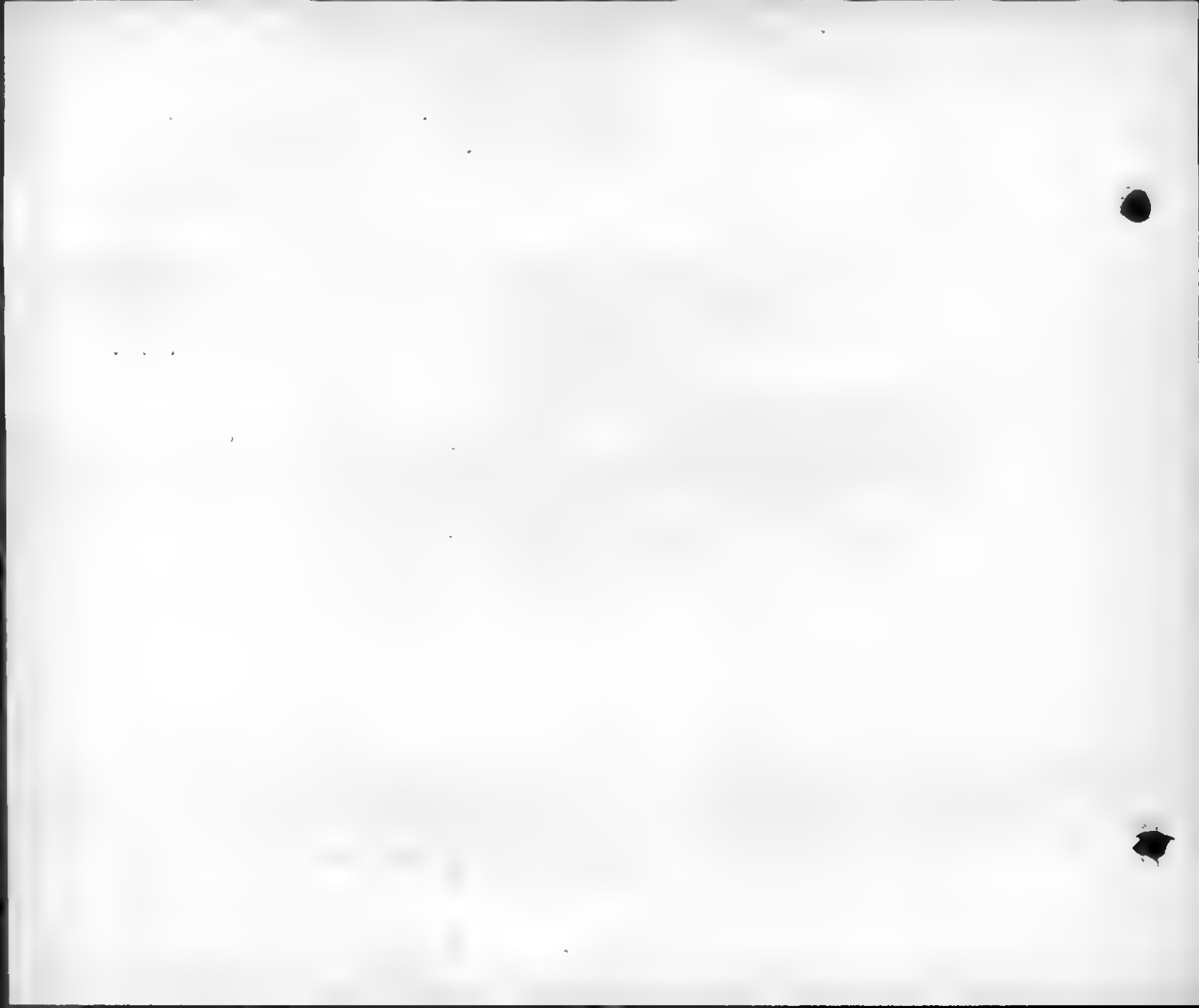
TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14491

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14428

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY WASH.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CLEAR SPRING		c. LENGTH OF STAY IN 1b 57 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BLAIRS VALLEY ROAD		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CLEAR SPRING RT 2	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN D. HOSE		4. DATE OF DEATH Month Day Year I 2 15 19 60	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 21 1882
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME DAVID B. HOSE		14. MOTHER'S MAIDEN NAME ELIZABETH GUESSFORD	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO. NONE	
17. INFORMANT Address WALTER L. HOSE CLEAR SPRING, RT 2, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Ac. Cardiac Failure</i> DUE TO (b) <i>Arterial + Cerebral Sclerosis</i> DUE TO (c) <i>5 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Jan 19 60 to Dec. 15, 1960 that (I) (we) last saw the deceased alive on Dec. 15, 1960, and that death occurred at 7 P.M. from the causes and on the date stated above			
22a. SIGNATURE David R. Brewer M.D.		22b. DATE SIGNED 12/16/60	
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/18/1960	
23c. NAME OF CEMETERY OR CREMATORY BLAIRS VALLEY		23d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS JOHN F. CLARK CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR DATE DEC 23 '60	
		25b. REGISTRAR'S SIGNATURE	



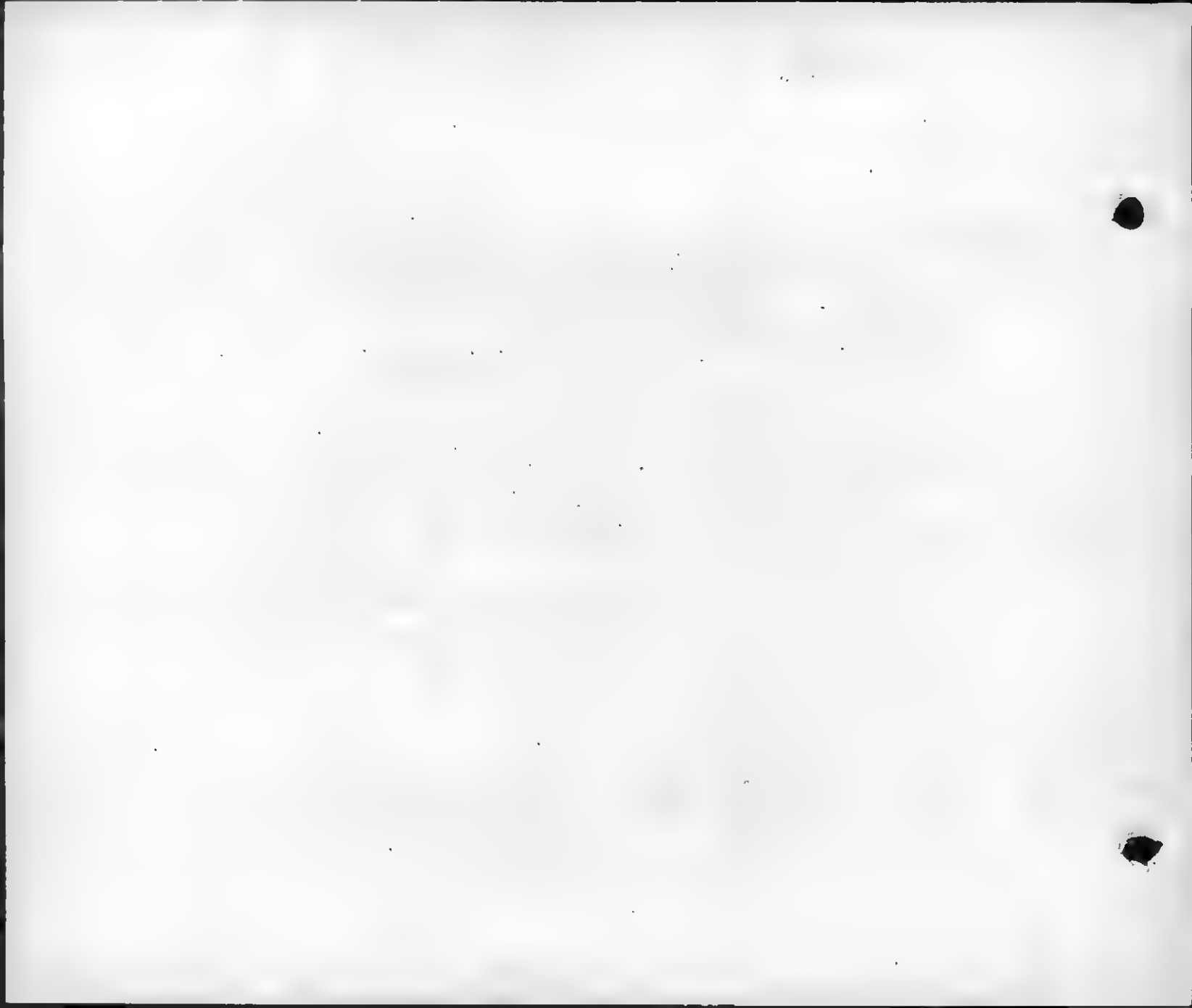
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14492

14423

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY VERMILION			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOBERSBURG RURAL		c. LENGTH OF STAY IN 1b 58 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SCOBERSBURG RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SCOBERSBURG MD. R. 2				d. STREET ADDRESS SCOBERSBURG MD. R. 2			
3. NAME OF DECEASED (Type or print) First Middle Last T. M. A. K. ITNYR				4. DATE OF DEATH Month Day Year DECEMBER 27 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 22 1876		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ZITTLERSTOWN WASH. D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM KAUFMAN				14. MOTHER'S MAIDEN NAME ANNIE KAUFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NAME		17. INFORMANT MRS. ROY HLEFFER Address SCOBERSBURG MD. R. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Atherosclerotic Heart Disease with myocordial infarct Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 yrs +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 15 1961 to 27 Dec 1961 that (I) (we) last saw the deceased alive on 26 Dec 1961, and that death occurred at 9 A. M. from the causes and on the date stated above.							
22a. SIGNATURE F. F. Lusby M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) F. F. Lusby				22d. ADDRESS 230 N. Potomac St			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 31 1961		23c. NAME OF CEMETERY OR CREMATORY SCOBERSBURG CEMETERY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. East				25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Evans	

14492





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

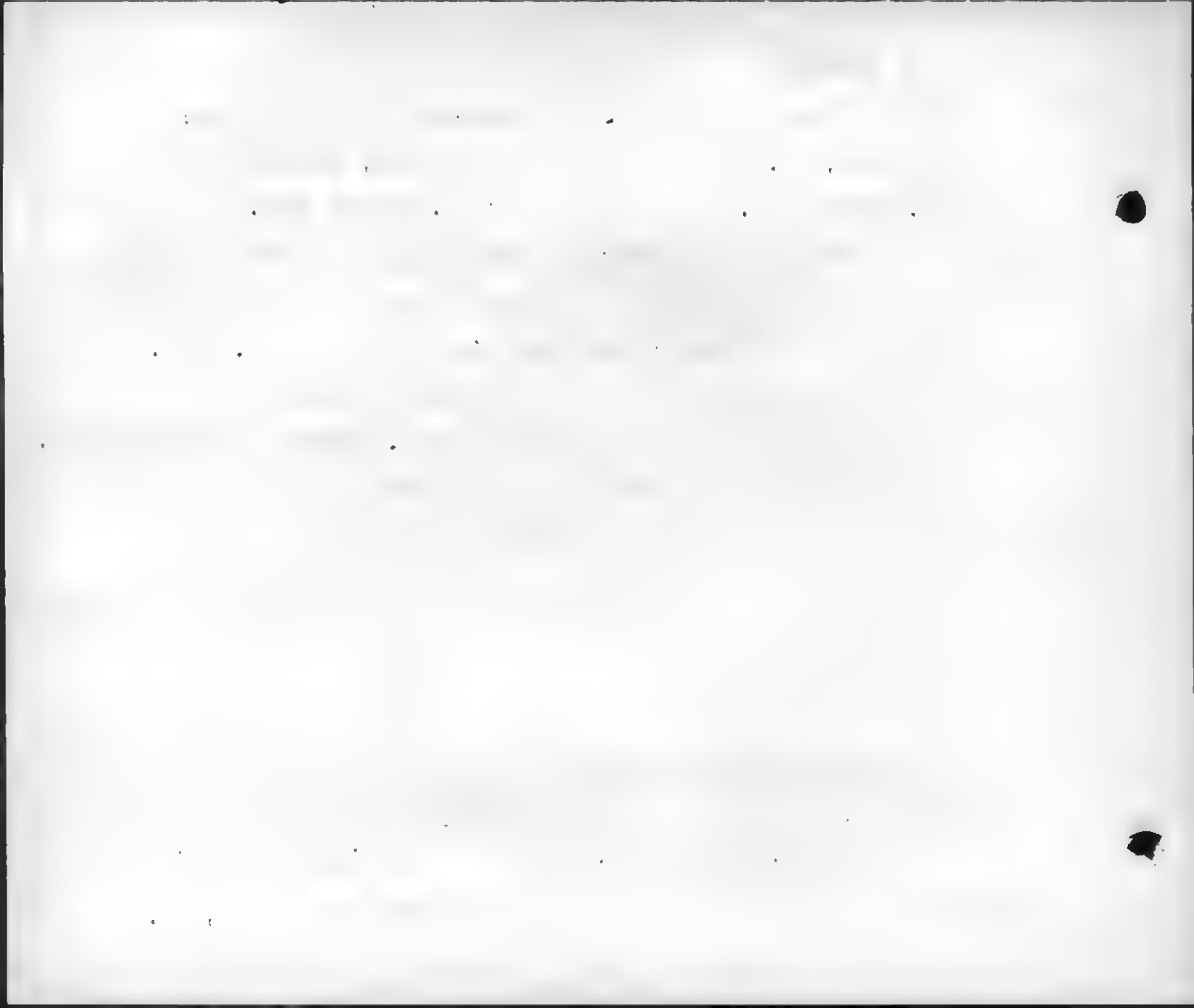
VR A15 (4)  
15M 9/59

14442

14430

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>421A. Sumans Ave.</b>				e. STREET ADDRESS <b>421A. Sumans Ave.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Daniel</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>Dec</b> Day <b>30</b> Year <b>19 60</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 26 1880</b>		9 AGE (In years last birthday) <b>80</b> yrs.	10 UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min <b>80</b>	11 UNDER 24 HRS Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min <b>80</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public utilities</b>		11. BIRTHPLACE (State or foreign country) <b>Amherst County Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>John Jones</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Seuba</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Sallie L. Summers 421A Sumans Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Obstructive Heart Disease</b> 4-20 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>6 mo.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 3</b> 19 <b>60</b> to <b>Dec 30</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Dec 12</b> 19 <b>60</b> , and that death occurred at <b>12</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Philip J. Hirshman</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>1/3/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 3 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Tolson Chapel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharpsburg, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson</b>				25a. REC'D BY REGISTRAR <b>JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Calvin S. Kline</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14493

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14493

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R #6 Rural Hagerstown		c. LENGTH OF STAY IN 1b 35 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural Hagerstown R#6		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LULA M KANE		4. DATE OF DEATH Month Day Year Dec. 21, 1960	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1892
9 AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-14-2029	
17. INFORMANT Albert Kane Hagerstown, Md. R#6 Northern Ave. Extd.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO 14 10:11 A.C. Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH Immediate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/21/60 to 12/21/60 that (I) (we) last saw the deceased alive on 12/21/60, and that death occurred at 12:11 P.M. from the causes and on the date stated above			
22a. SIGNATURE Ralph F. Young M.D.		22b. DATE SIGNED 12/23/60	
22c. PHYSICIAN'S NAME (Type) Ralph F. Young		22d. ADDRESS 101 E. Potomac St. Williamsport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/60	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 27 '60 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Knease	

Wm. A. Horst



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14478

14462

14478

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WILLIAMSPORT</b>				c. LENGTH OF STAY IN 1b <b>4 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WILLIAMSPORT SANITARIUM</b>				d. STREET ADDRESS <b>1828 1/2 VIRGINIA AVE.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>GENEVA</b> Last <b>KEEDY</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5/29/1884</b>	
9. AGE (in years last birthday) <b>76 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>O THA KEEDY</b>				14. MOTHER'S MAIDEN NAME <b>HARRIETTE ROHRER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-07-8860</b>		17. INFORMANT <b>MR. NORMAN D. ROWLAND</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1953</b> to <b>12/17</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>12/17</b> , 19 <b>60</b> , and that death occurred at <b>6:52 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>George Turnings</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Turnings</b>				22d. ADDRESS <b>136 W. Washington St., Hagerstown</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEM.</b>		23d. LOCATION (City, town, or county) _____ (State) <b>MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. Norment</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14443

14453

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1-11-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>W.</u> Last <u>Kefauver</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1960</u>			
5 SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/5/1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>19</u> Min.		IF UNDER 24 HRS Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>matron, ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>railway</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Richard Kefauver</u>				14. MOTHER'S MAIDEN NAME <u>Laura Toms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO <u>none</u>			
17. INFORMANT <u>Dr. Noah E. Kefauver, Middletown, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>33</u> DUE TO <u>thrombotic cerebrovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary thrombosis</u> DUE TO (c) <u>34</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>34</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 16</u> 19 <u>59</u> to <u>Dec 19</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Dec 19</u> 19 <u>60</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. W. LeVan</u>				22b. DATE SIGNED <u>DEC 21 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Gerald W. LeVan</u>	
22d. ADDRESS <u>Boonsboro, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/22/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 21 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	





TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

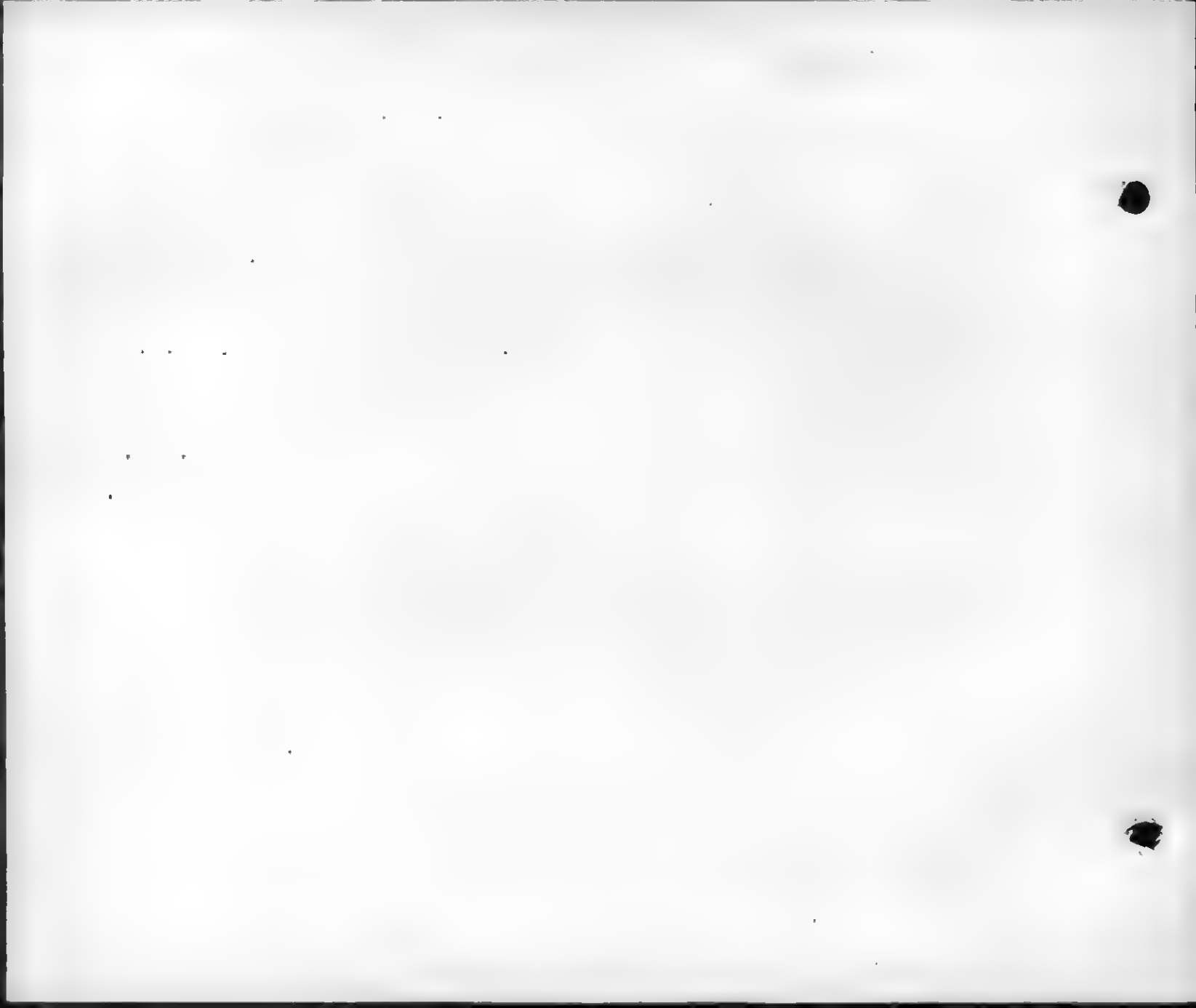
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14479

14454

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington Co. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Berkeley	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg	
c. LENGTH OF STAY IN lb 9 days		d. STREET ADDRESS 507 Lincoln Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Wilson Daniel Kelchner		4. DATE OF DEATH Month Day Year Dec. 8 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5 1872
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months 6 Days 2	
11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer		10b. KIND OF BUSINESS OR INDUSTRY Marine Towing Co. Shoemakersville Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry Kelchner		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT John Kelchner		Address 507 Lincoln Drive Martinsburg W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Sepsis, Bacterial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary abscess DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 hrs 1 mo?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Dec 1 1860 to Dec. 8 1960, that (I) (we) last saw the deceased alive on Dec 6 1960, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE M E Byrkit		22b. DATE SIGNED 12-8-60	
22c. PHYSICIAN'S NAME (Type) M E Byrkit		22d. ADDRESS 2840 Potomac Williamsport MD	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 12 1960	
23c. NAME OF CEMETERY OR CREMATORY The Evergreen Cemetery		23d. LOCATION (City, town, or county) Brooklyn New York (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Self Williamsport, Md		25a. REC'D BY REGISTRAR DATE 12 00	
25b. REGISTRAR'S SIGNATURE Albert L. Self			

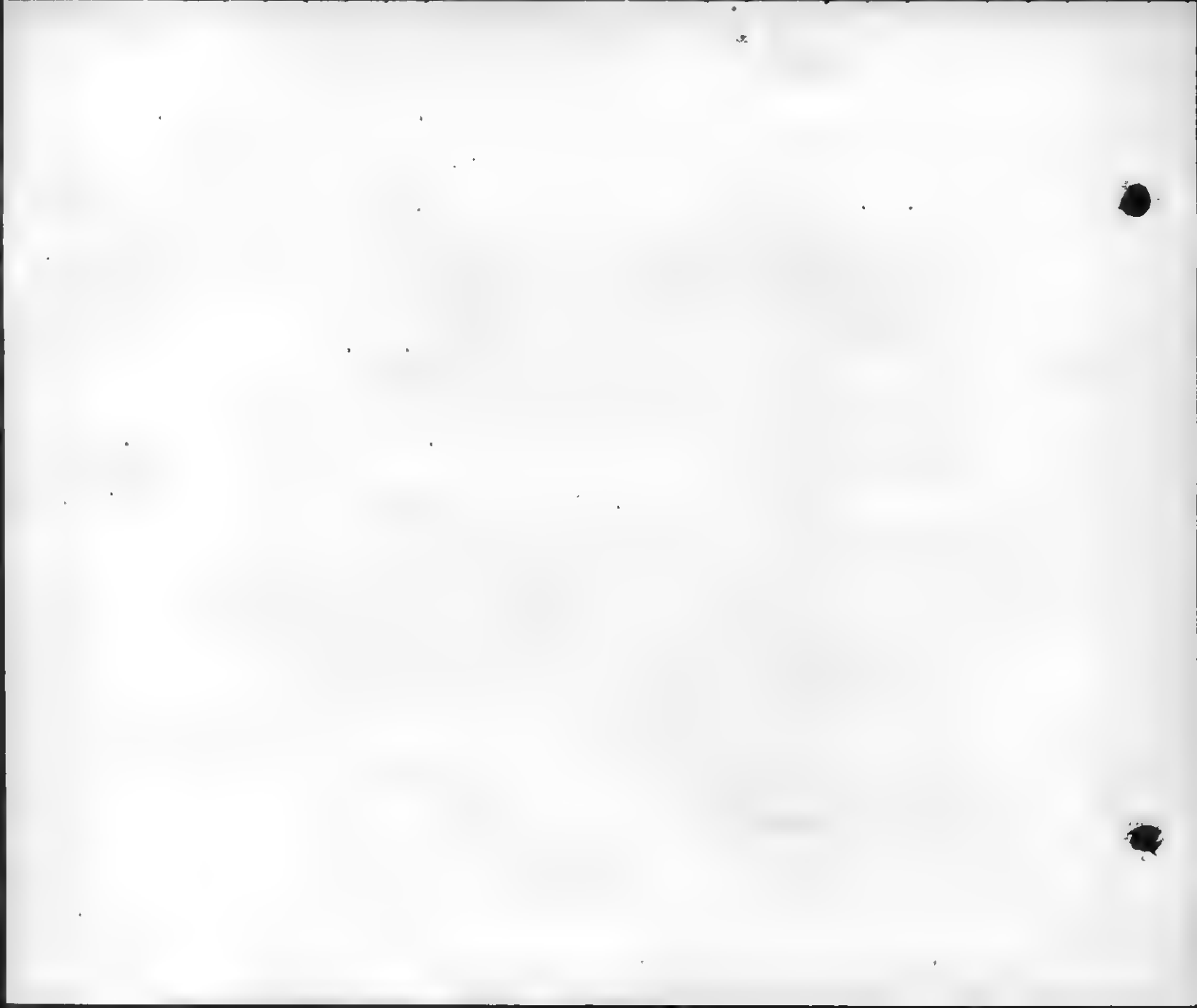


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14435

14444

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>DOA</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hos ital</b>				d. STREET ADDRESS <b>129 W. Bethel</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>Maynard</b> Middle <b>L</b> Last <b>Keyser</b>				4. DATE OF DEATH Month <b>12</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-30-1893</b>	
9 AGE (In years last birthday) <b>67 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cab driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own</b>		11. BIRTHPLACE (State or foreign country) <b>Page Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Keyser</b>				14 MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17 INFORMANT <b>Molder C. Keyser</b> Address <b>Hagerstown, Md.</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. <b>420.1</b> IMMEDIATE CAUSE (a) <b>acc. hypochondrial infarction</b> DUE TO (b) <b>INTERVAL BETWEEN ONSET AND DEATH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/13/60</b> 19 to <b>12/13/60</b> 19, that (I) (we) last saw the deceased alive on <b>12/13/60</b> 19, and that death occurred at <b>7:15</b> M, from the causes and on the date stated above.							
22a SIGNATURE <b>Fred W. Kraiss</b>		22c PHYSICIAN'S NAME (Type) <b>Fred W. Kraiss</b>		22b. DATE SIGNED <b>DEC 13 1960</b>		22d ADDRESS	
23a BURIAL CREMATION REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12-15-60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				25a REC'D BY REGISTRAR DATE <b>DEC 19 1960</b>		25b REGISTRAR'S SIGNATURE <b>...</b>	

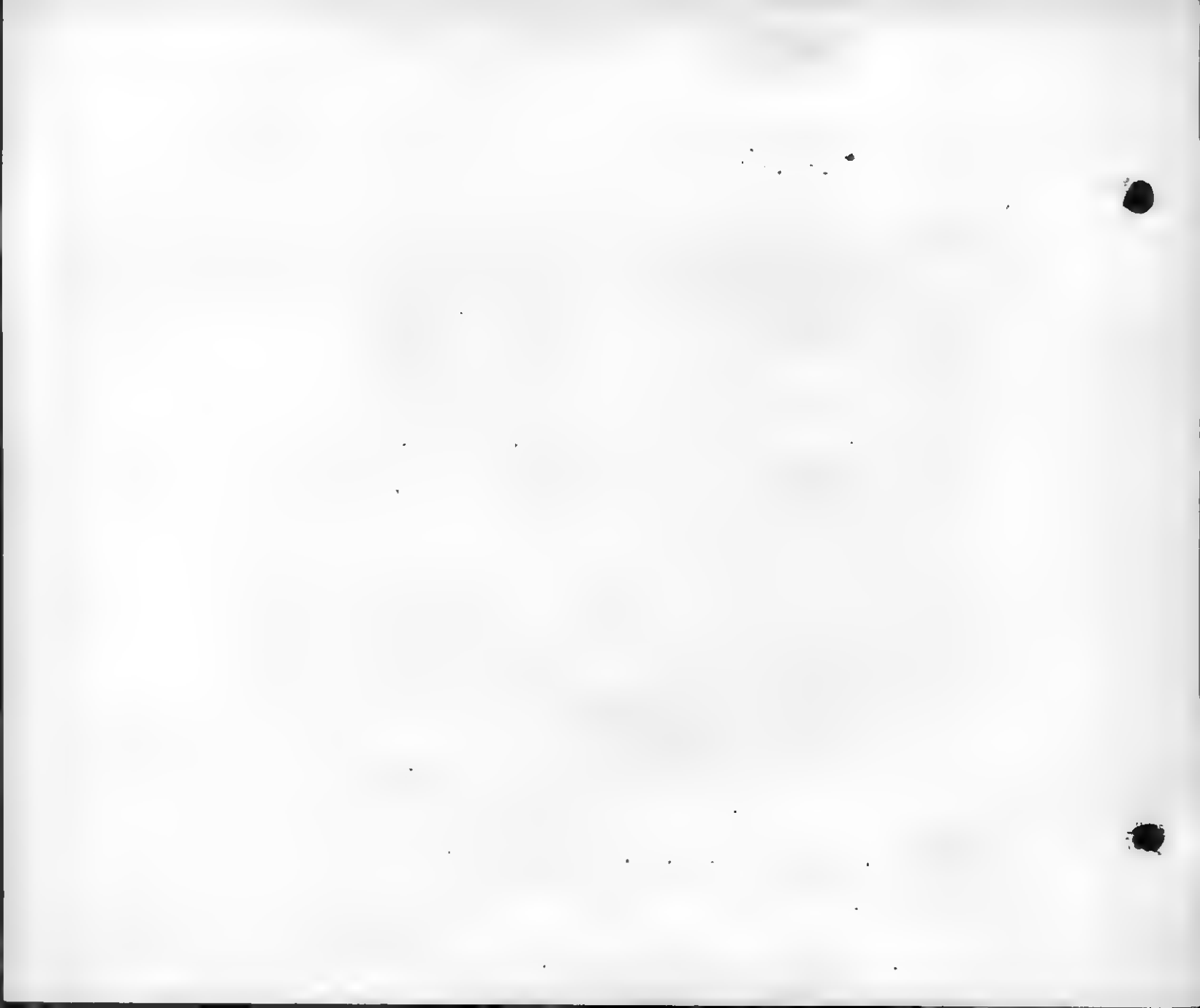


TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND <b>CERTIFICATE OF DEATH</b>									
<b>1 PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <b>MARYLAND</b>					<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>521 Guilford Ave</b>					d. STREET ADDRESS <b>521 Guilford Ave</b>				
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>CARRIE LEE LEWIS</b>					<b>4. DATE OF DEATH</b> Month Day Year <b>December 9 1960 19</b>				
<b>5 SEX</b> <b>Female</b>		<b>6 COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 24 1874</b>		<b>9. AGE</b> (In years last birthday) <b>86</b> yrs IF UNDER 1 YEAR: Months Days Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11 BIRTHPLACE</b> (State or foreign country) <b>Shenandoah Co Va</b>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Isaac Hess</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Magdelene</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16 SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Mrs. Anna L. Jones, 521 Guilford Ave</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>430.0</b> DUE TO <b>general arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> (c)								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21 I certify that (I) (this hospital) attended the deceased from Dec 1 1960 to Dec 9 1960. that (I) (we) last saw the deceased alive on Dec 8 1960, and that death occurred at 9:45 PM, from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <b>Edward W. Ditto M.D.</b>					<b>22b. DATE SIGNED</b> <b>12/9/60</b>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edward W. Ditto M.D.</b>					<b>22d. ADDRESS</b> <b>217 West Washington Street</b>				
<b>23a BURIAL, CREMATION REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>12/12/60</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rest Haven Cemetery</b>			<b>23d. LOCATION (City, town, or county)</b> (State) <b>Hagerstown Wash Co Md</b>		
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Andrew K. Coffman, Hagerstown, Md</b>					<b>25a. REC'D BY REGISTRAR</b> <b>DEC 19 '60</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>C. W. L. [Signature]</b>		

MEDICAL CERTIFICATION

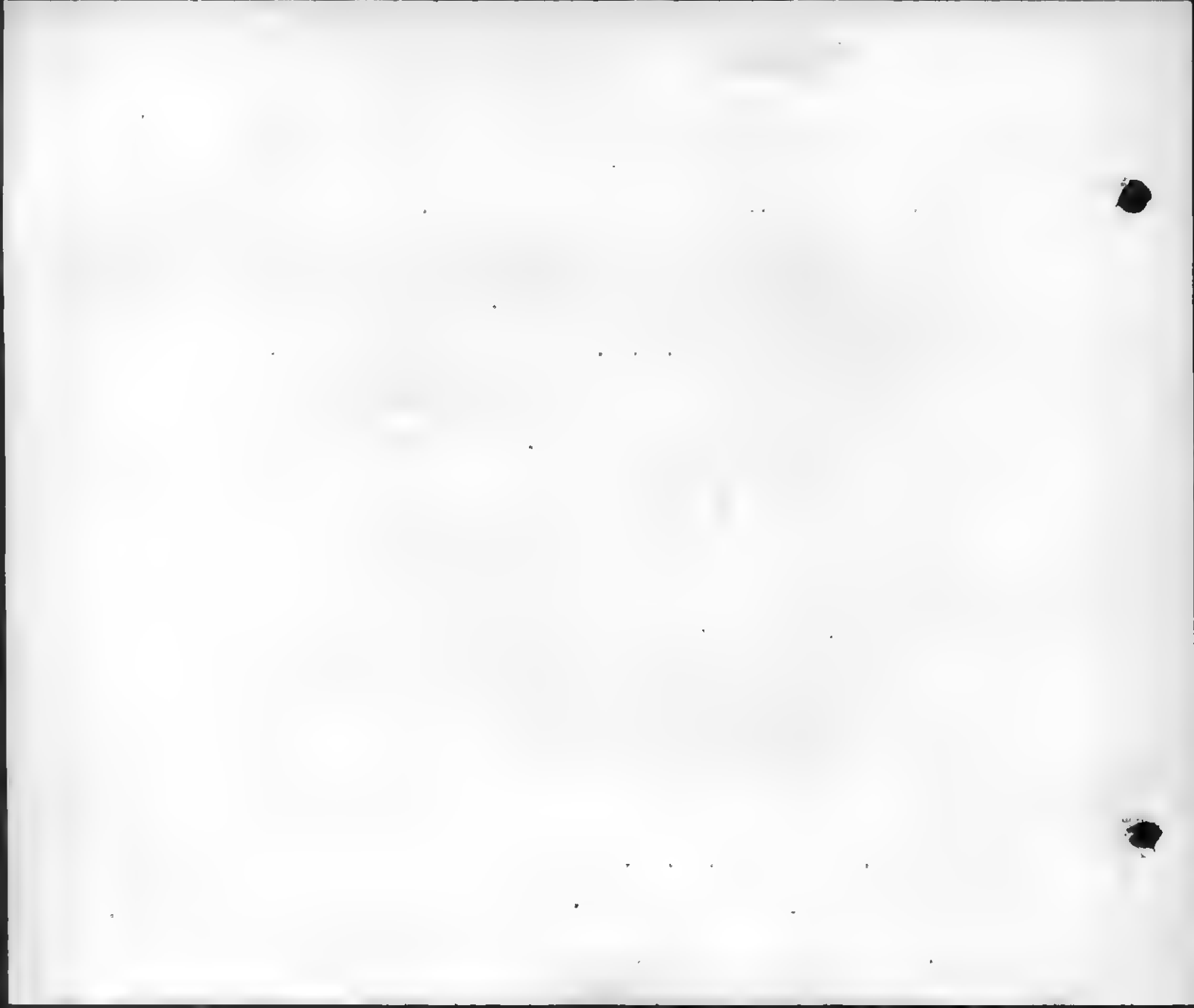


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**14446** **CERTIFICATE OF DEATH** **14437**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>829 W. Franklin St.,</b>				d. STREET ADDRESS <b>829 W. Franklin St.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Elmer</b> Last <b>Lightner</b>				4. DATE OF DEATH Month <b>12</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 5, 1877</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>		11. IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired conductor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Penn. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>Chambersburg, Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ignatius Lightner</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Strock</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>716-63-2075</b>		17. INFORMANT <b>Mrs. Lula Lightner</b> Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>sen'l arteriosclerosis</b> DUE TO <b></b> (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign prostatic hypertrophy</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <b></b> Day <b>19</b> Year <b></b> Hour <b></b> a. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1</b> 19 <b>60</b> to <b>Dec 9</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Dec 9</b> 19 <b>60</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Edward W. Ditto III</b>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>12/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				22d. ADDRESS <b>217 West Washington Street</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12-12-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Norland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Chambersburg Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> Address <b>Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 14 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.







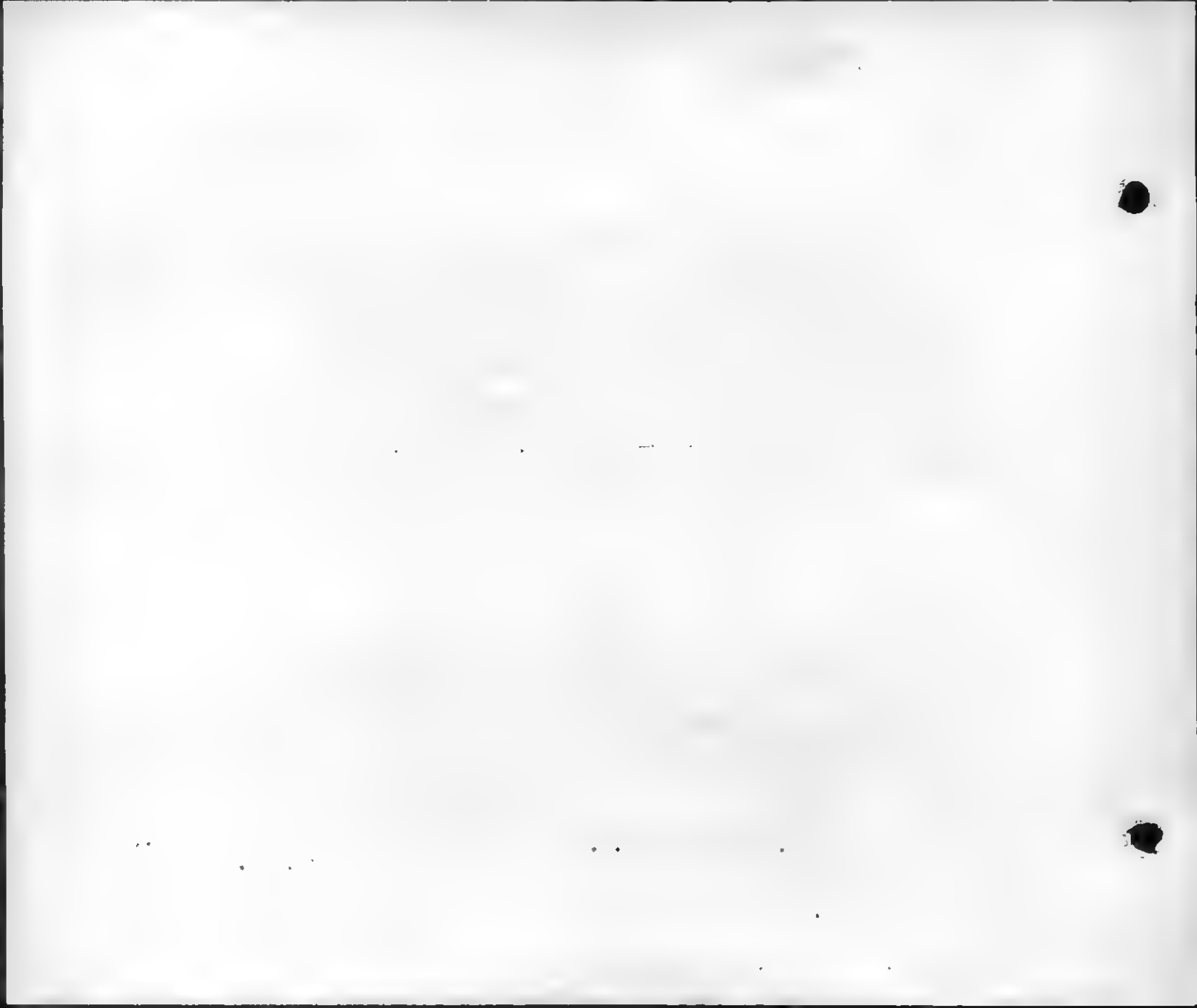
## 14447

# CERTIFICATE OF DEATH

302

14438

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN IB <b>4 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		<b>CS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>337 Ridge Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EARL SEYLORE LINT</b>		First Middle Last		4. DATE OF DEATH <b>December 17, 1960</b>		Month Day Year	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 30 1896</b>	
9. AGE (In years last birthday) <b>63 yrs</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Koppers Co</b>		11. BIRTHPLACE (State or foreign country) <b>Dawson Fayette Co Pa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Stewart Lint</b>		14. MOTHER'S MAIDEN NAME <b>Martha Spellman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-3457</b>		17. INFORMANT <b>Mrs. Irene E. Lint</b>		Address <b>337 Ridge Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4 1/2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Anteroseptal Coronary Heart Disease</b> DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH <b>3 days - about 6 or 7 years</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-28 1945</b> to <b>12-17, 1960</b> , that (I) (we) last saw the deceased alive on <b>12-17 1960</b> and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>John H. Hornbaker</b>		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12:17:60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md</b>		25a. REC'D BY REG STRAR DATE <b>DEC 21 '60</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. W.</b>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

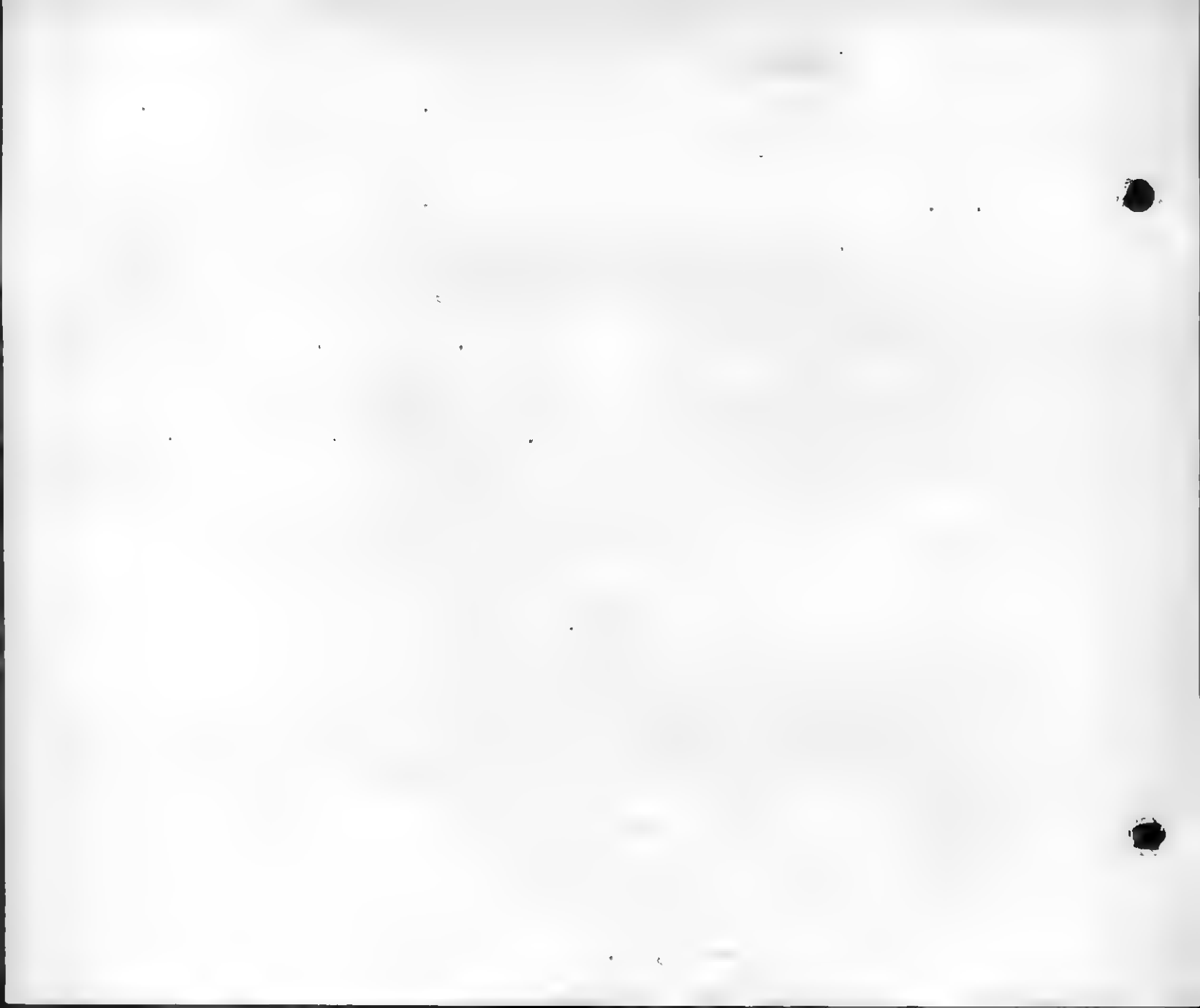
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14439

14448

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>W. Md. State Hospital</b>		d. STREET ADDRESS <b>603 N. Mulberry</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Grace</b> First <b>Maude</b> Middle <b>MARTIN</b> Last		4. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1874</b>
9. AGE (In years, last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homeduties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>St. Thomas, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James William Sellers</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Ramer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Olive Jones</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease, valvular, inactive</b> DUE TO (c) <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>① Fracture Rt. hip ② General arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on own backyard</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>Sept. 22, 1960</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown, Washington, Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 13, 1960</b> , to <b>Dec 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec 15, 1960</b> , and that death occurred at <b>10:10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>		22b. ADDRESS <b>Western Md. State Hospital, Hagerstown, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICTOR L. RAMOS, M.D.</b>		22d. ADDRESS <b>Western Md. State Hospital, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>12-19-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>DEC 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>W. L. Thomas</b>	



Wm. G. Horst

VR A15 (4)  
1SM 9/59



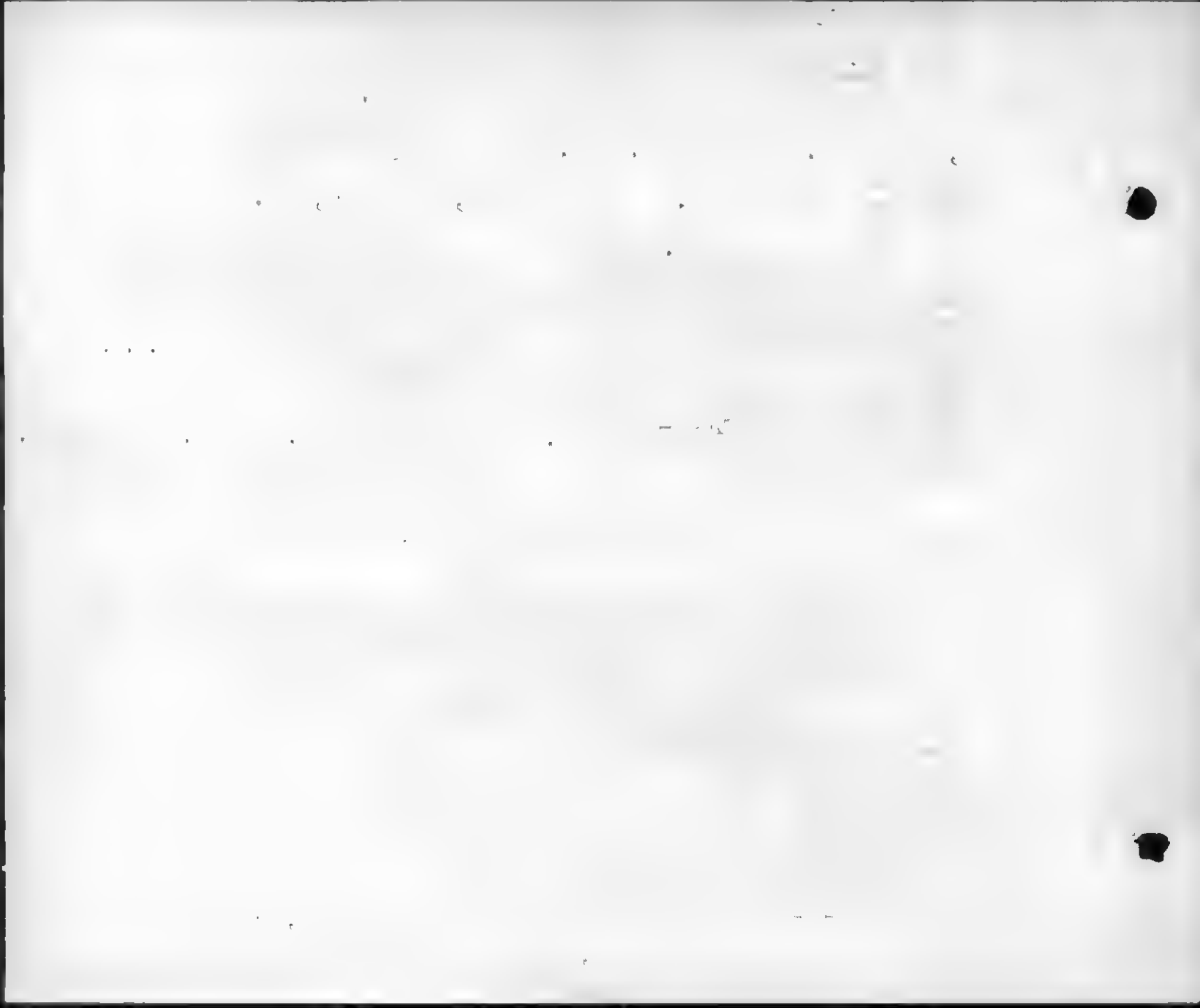
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **14441**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Washington</b> <span style="float: right;">14494</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Hagerstown.</b> c. LENGTH OF STAY IN 1b <b>1 yr. 3 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fahney Keedy Nursing Home.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland.</b> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> d. STREET ADDRESS <b>Rural, Boonsboro, Md.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Jemima F. Murdock</b>		<b>4. DATE OF DEATH</b> Month <b>December</b> Day <b>19</b> Year <b>1960</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>May 19, 1869</b>
<b>9. AGE</b> (In years last birthday) <b>91</b> yrs		<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Frederick County, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Jesse Walker</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Jemima Moxley</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>211-16-0828 D</b>	
<b>17. INFORMANT</b> <b>Mr. Wallace Mount</b>		Address <b>1037 S. 17th St. Arlington, Va.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> DUE TO <b>450.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Bilateral lobar pneumonia -</b> DUE TO _____ (c) _____			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 yrs 10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____ 19____	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <b>Dec 9</b> , 19 <b>60</b> , to <b>Dec 19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Dec 18</b> , 19 <b>60</b> , and that death occurred at <b>3 P. M.</b> , from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>G. W. Hedan</b> M.D.		<b>ADDRESS</b> (Street, city or town, state) <b>Boonsboro</b> <b>DATE SIGNED</b> <b>12/19/60</b>	
<b>PHYSICIAN'S NAME (Type)</b> <b>G. W. Hedan</b>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	
<b>22b. DATE THEREOF</b> <b>12-23-1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Pleasant Hill Cemetery</b>	
<b>22d. LOCATION</b> (City, town, or county) (State) <b>Monrovia, Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DEC 27 '60</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert E. Gifford</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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14450

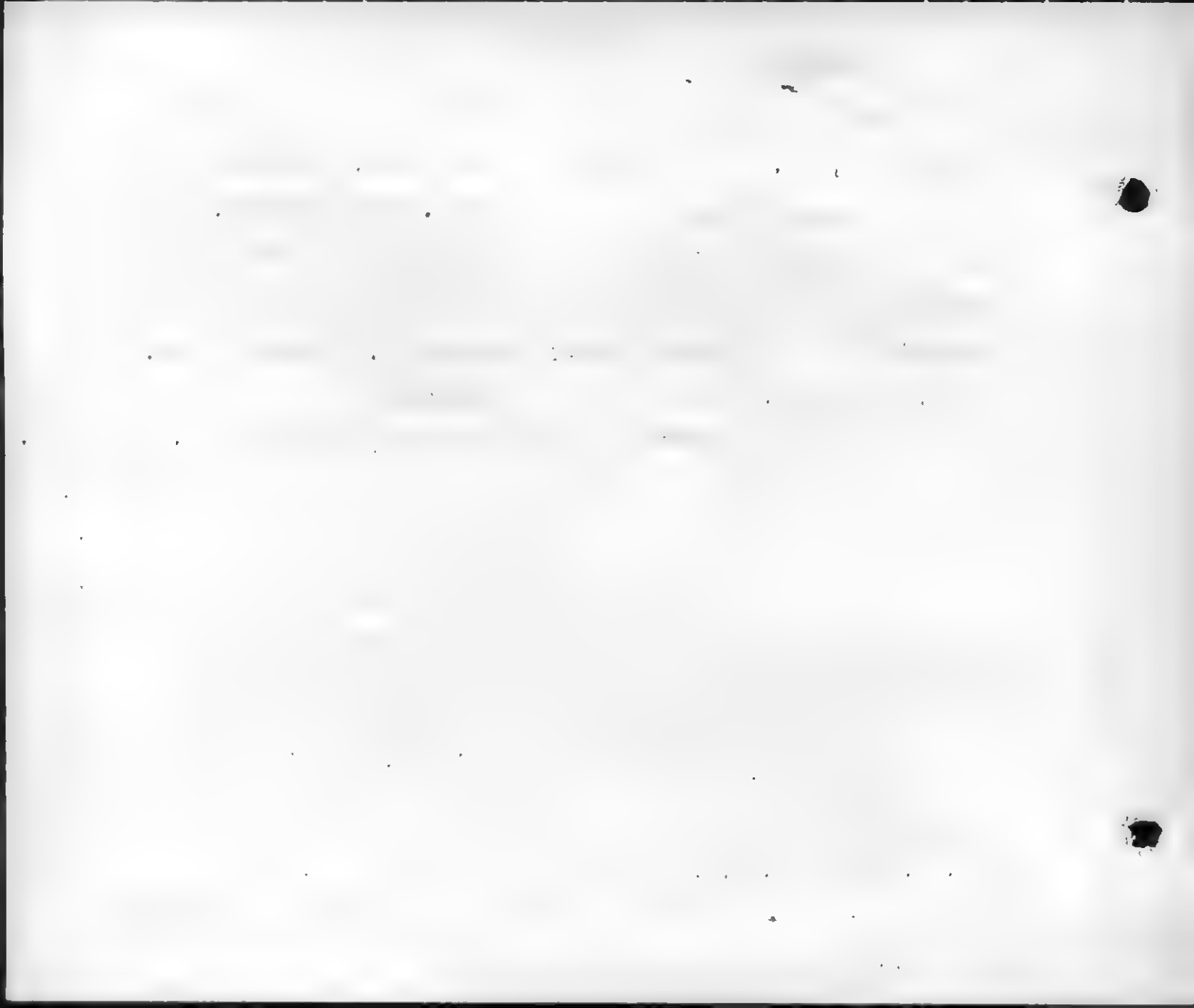
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14442

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>70 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 W Bethel Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Daisy Louis Nickens</b>				4 DATE OF DEATH Month Day Year <b>Dec 14 19 60</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 12 1877</b>		9. AGE (In years last birthday) yrs <b>83</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		11 BIRTHPLACE (State or foreign country) <b>Brunswick, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13 FATHER'S NAME <b>Charles Nickens</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16 SOCIAL SECURITY NO. <b>none</b>		17 INFORMANT Address <b>Mrs Henrietta Salters 120 W. Bethel st.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Hypertensive vascular disease</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>10 yr.</b> <b>10 yr.</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (1) (this hospital) attended the deceased from <b>Dec 11-50</b> to <b>Dec 14 1960</b> , that (2) (we) last saw the deceased alive on <b>Dec 9 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>B. B. Kneisley, M.D.</b>				22b. DATE SIGNED <b>12/16/60</b>			
22c PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>				22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Dec 17 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson of Hagerstown Md.</b>				25a RECD BY REGISTRAR <b>DEC 20 60</b>		25b REGISTRAR'S SIGNATURE <b>Robert S. Frank</b>	

MEDICAL CERTIFICATION

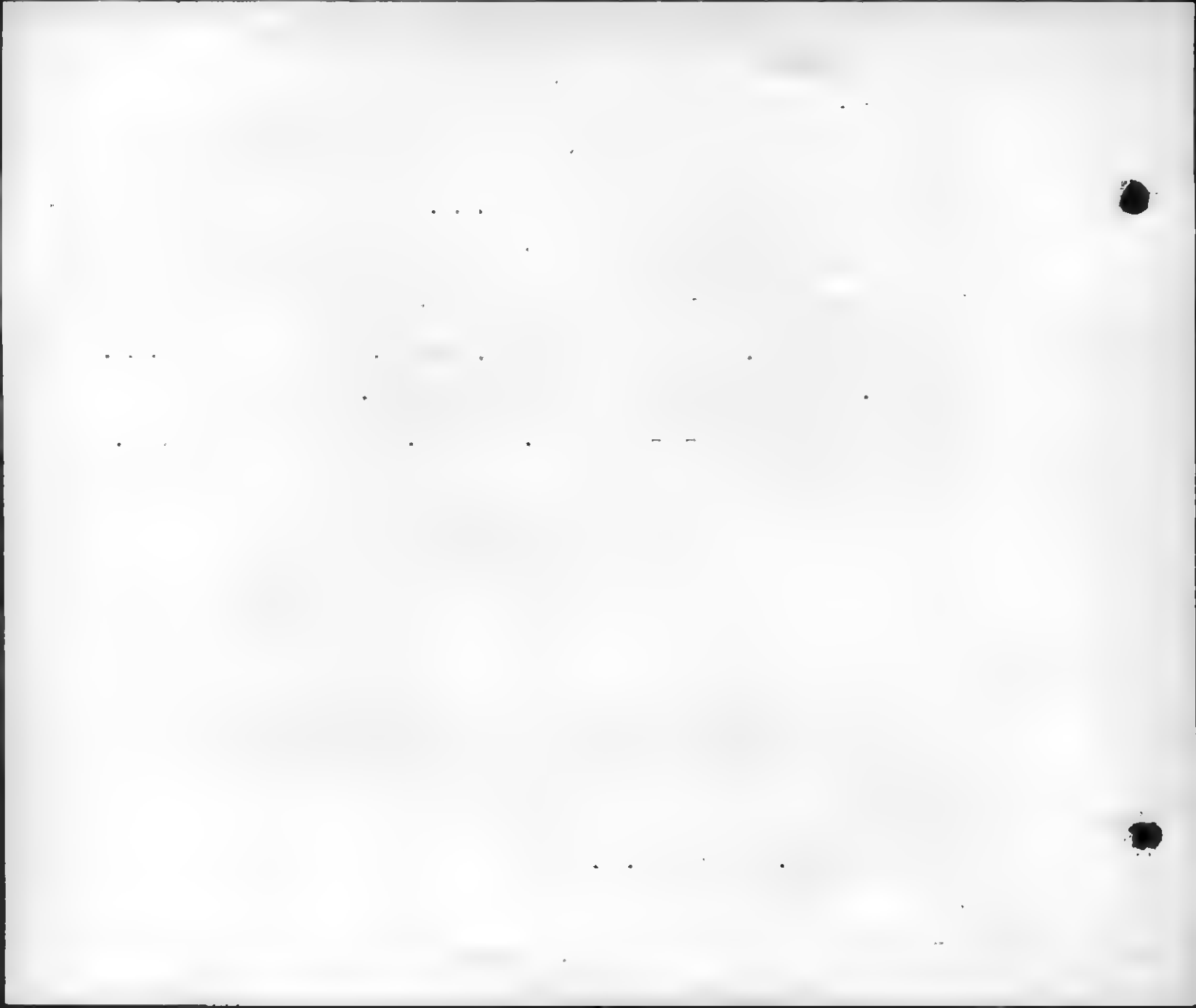


may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14451

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
14443  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>most of life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Williamsport</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CHARLES</b> Last <b>O'CONNELL II</b>				4. DATE OF DEATH Month <b>December</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 30, 1880</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Secretary-Tres.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Publishing Co.</b>			
11. BIRTHPLACE (State or foreign country) <b>Mobile, Alabama</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John C. O'Connell</b>				14. MOTHER'S MAIDEN NAME <b>Lucy M. Merritt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-2262</b>		17. INFORMANT Address <b>Mrs. Howard T. Woods Williamsport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>610X</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostatic Hypertrophy &amp; chronic pyelonephritis</b> DUE TO (c) <b>7.10 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic Heart Disease. Hemorrhagic stroke media-</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6/25, 1957</b> to <b>12/1, 1960</b> , that (I) (we) last saw the deceased alive on <b>12/1, 1960</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>John H. Hornbaker</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12-2-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker M. D.</b>				22d. ADDRESS <b>Hagerstown, Maryland</b>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/3/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Weyer</b>				ADDRESS <b>Hagerstown, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 5 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

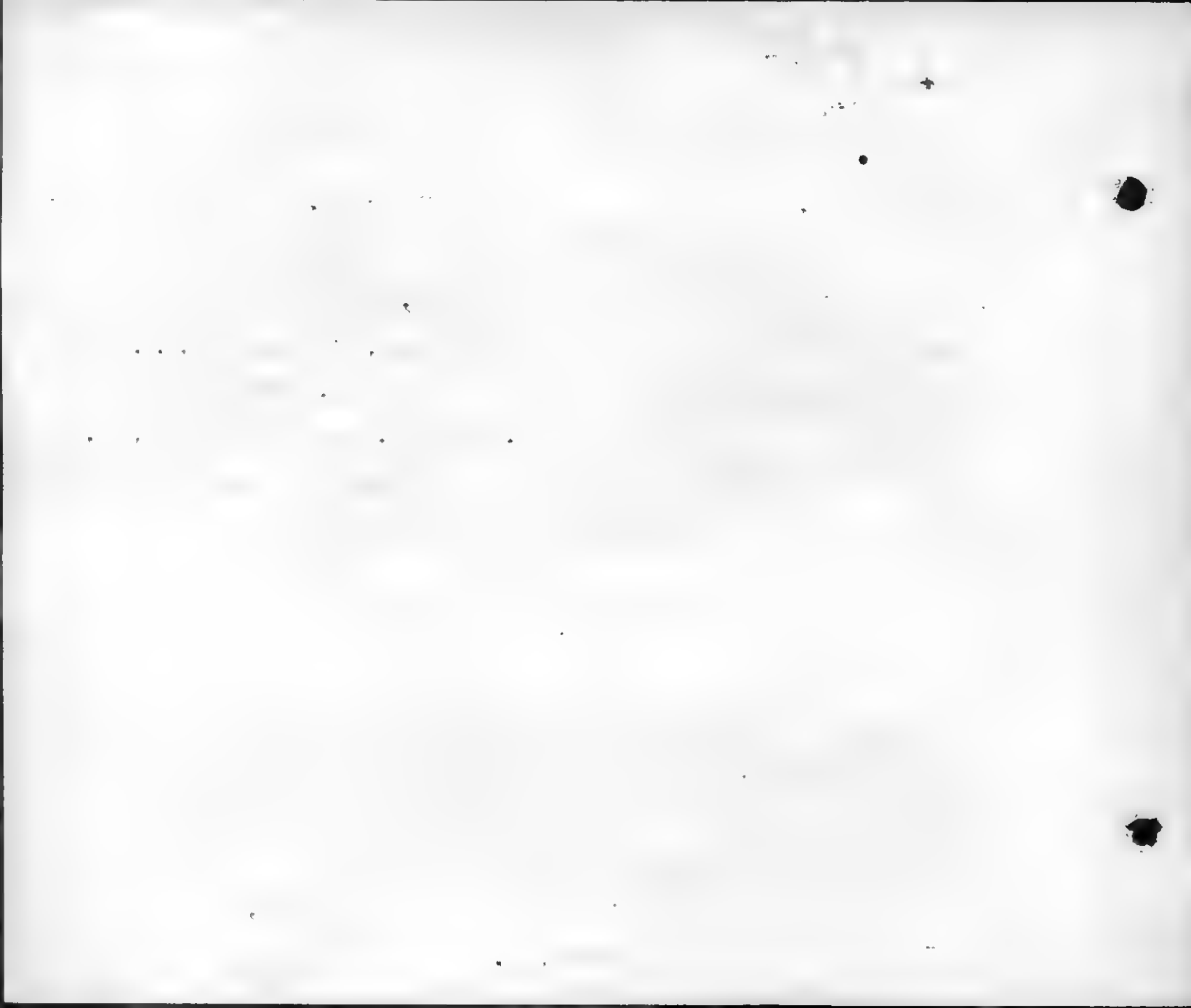
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14452

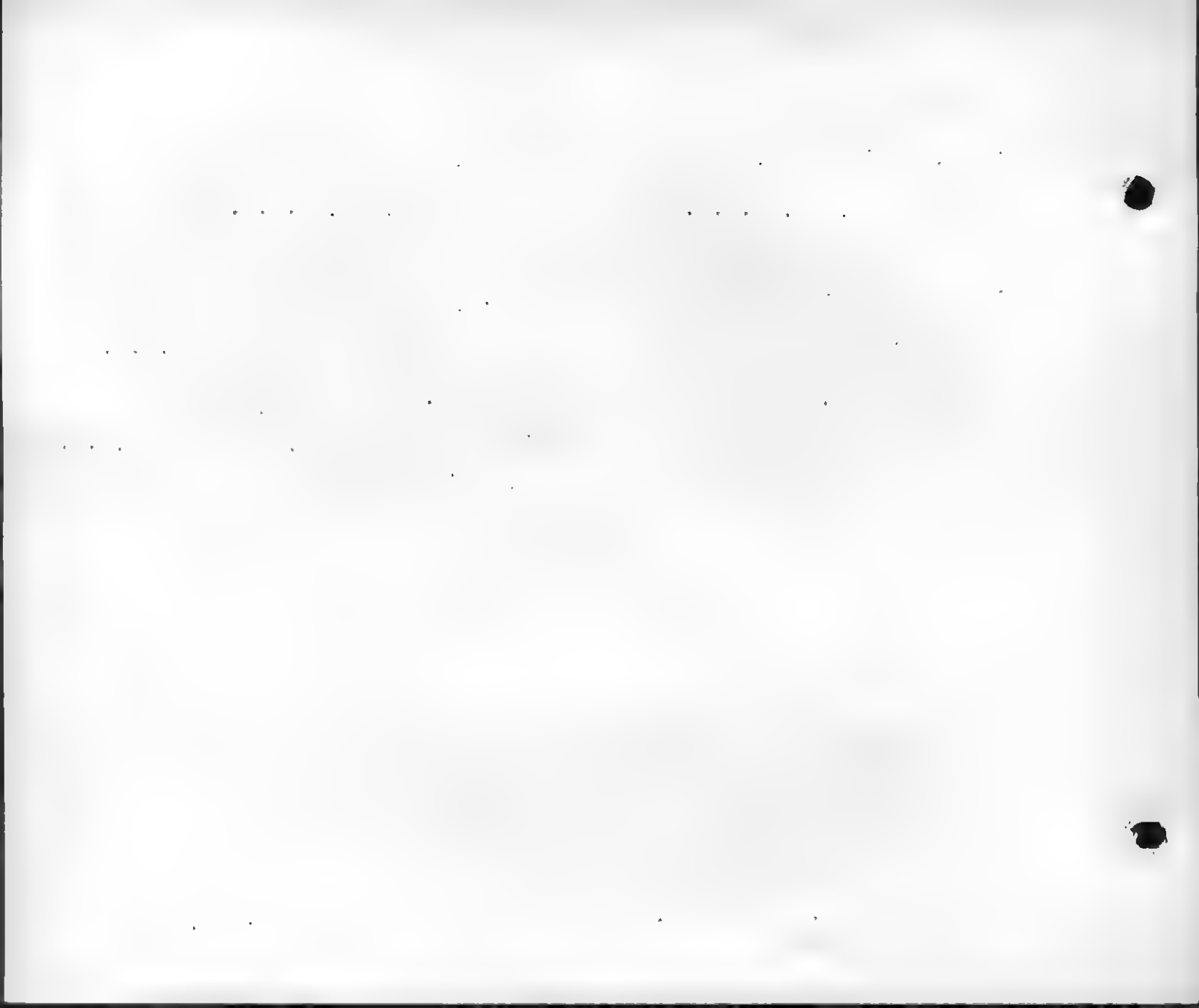
STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14444

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>47 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>424 Guilford Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>CRABILL</b> Last <b>OGDEN</b>		4. DATE OF DEATH Month <b>December</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 19, 1881</b>
9. AGE (in years last birthday) <b>78 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Toms Brook, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Nathaniel Tewalt</b>		14. MOTHER'S MAIDEN NAME <b>Frances E. Crabill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Lucille E. Brunner</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ <b>None.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 20, 1956</b> to <b>Dec. 8, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov. 30, 1960</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above			
22a. SIGNATURE <i>R.A. Bell</i>		22b. DATE SIGNED <b>Dec. 9, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.A. Bell, M.D.</b>		22d. ADDRESS <b>Hagerstown, Maryland.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/10/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Suter - Rouzeur</i>		25a. REC'D BY REGISTRAR <b>DEC 14 '60</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>C. L. ...</i>	









TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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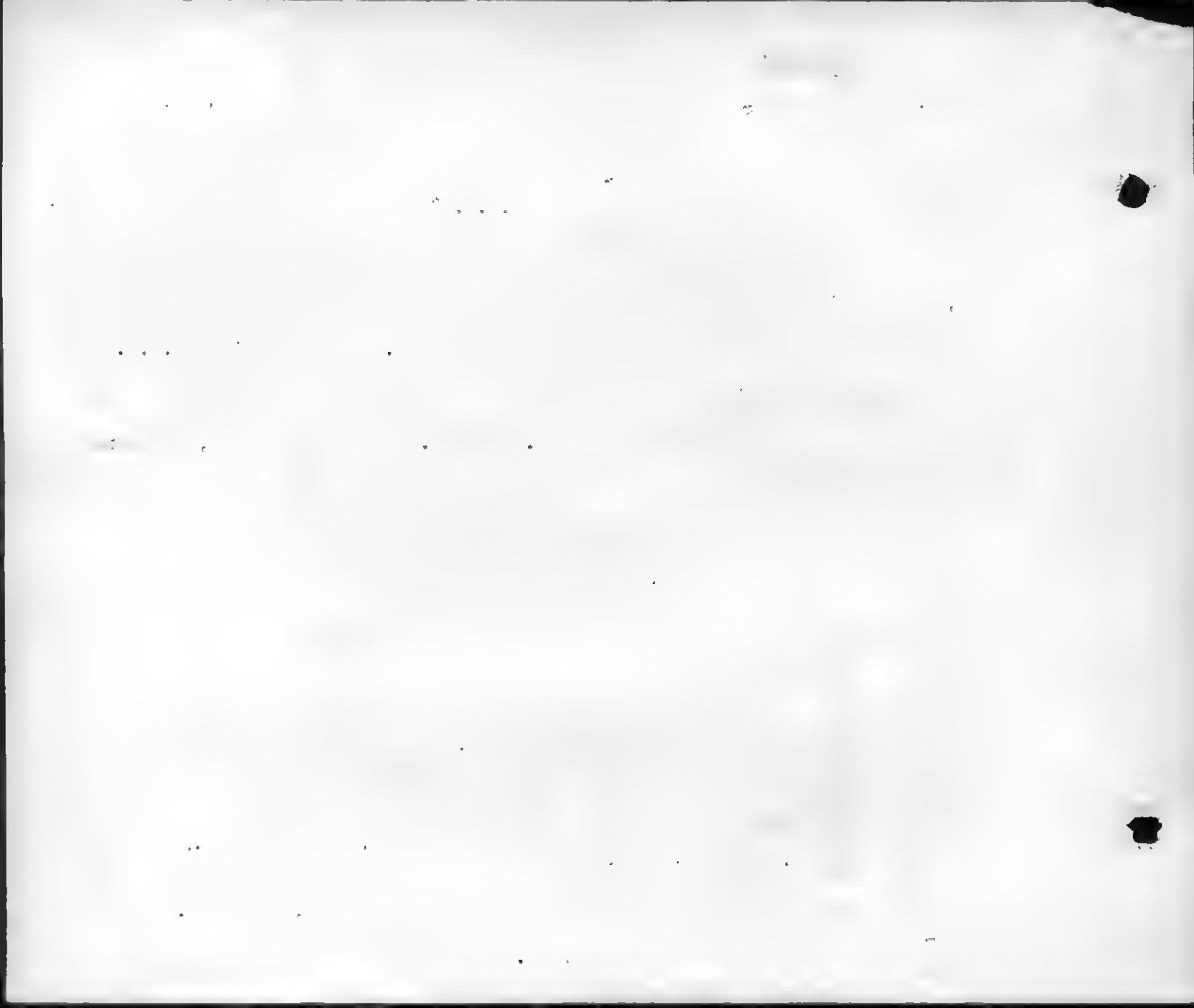
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14453

14446

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>44 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>R.F.D. # 2</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDITH DE ARMIT PARIS</b>				4. DATE OF DEATH Month Day Year <b>December 28 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 1, 1889</b>	
9. AGE (In years last birthday) <b>71 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Cameron Co., Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Austin De Armit</b>				14. MOTHER'S MAIDEN NAME <b>Anna Piper</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Lamar D. Paris</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 430.4 DUE TO Conditions if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>Coronary Insufficiency</b>				INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>?</b> <b>1 mo</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 27, 19 60</b> to <b>Dec 28, 19 60</b> , that (I) (we) last saw the deceased alive on <b>Dec 28, 19 60</b> , and that death occurred at <b>3:40 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Philip J. Hirshman</i>				22b. DATE SIGNED <b>12/29/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>				22d. ADDRESS <b>159 W. Washington St. Hagerstown, Maryland</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/31/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Keyser, W. Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. E. Rousler</i>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '61</b>	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>							



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14454

14447

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>5 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>2457 Virginia Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Albert Henry Pfeiffer</b>				4. DATE OF DEATH Month Day Year <b>December 6 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 21, 1909</b>		9. AGE (In years lost b rthday) yrs <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min <b>1 day 4 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>		11. BIRTHPLACE (State or foreign country) <b>Bedford Co. Penn.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles E. Pfeiffer</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Witt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>214-07-4314</b>		17. INFORMANT Address <b>Mrs. Nellie E. Pfeiffer Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <b>420.0</b>            PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)  <b>Common Cardiac Arrhythmia</b> </div> <div> <b>1 day 4 yrs.</b>            INTERVAL BETWEEN ONSET AND DEATH         </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 9</b> <b>1960</b> to <b>Dec 6</b> <b>1960</b> that (I) (we) last saw the deceased alive on <b>Dec 5</b> <b>1960</b> and that death occurred at <b>12:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Phillip J. Mirshman</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>12/6/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Phillip J. Mirshman</b>				22d. ADDRESS <b>159 W. Washington St. Hagerstown, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-9-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Gardens</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Scott P. Minnich ~ Son Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>DEC 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. SECONDARY

14496

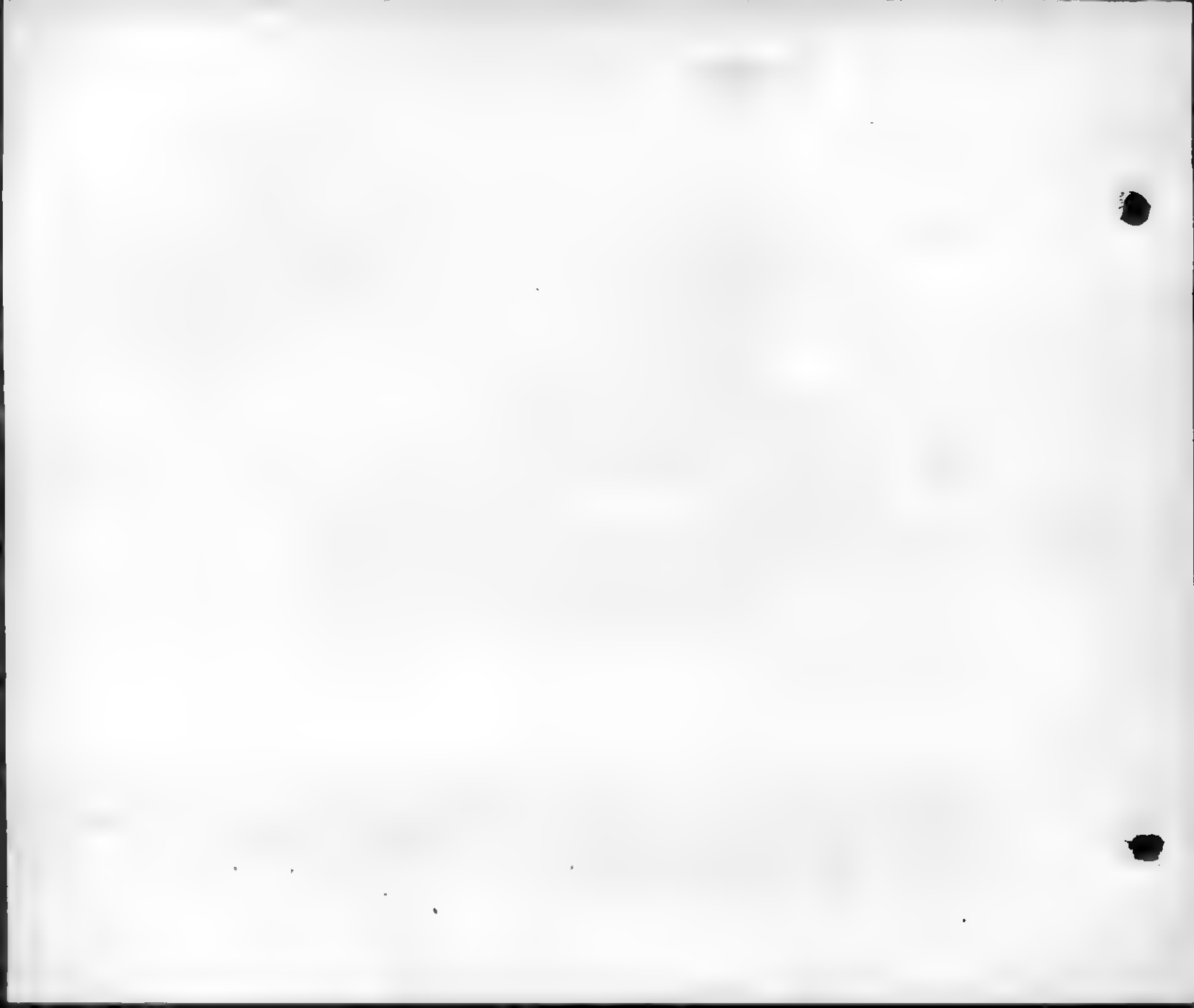
14448

1

14496

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEEDYSVILLE</u>				c. LENGTH OF STAY IN 1b <u>12 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>WALTER</u> Last <u>POFFENBERGER</u>				4. DATE OF DEATH <u>DEC. 28</u> 19 <u>60</u> Month <u>DEC</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 12, 1889</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>16</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARM WORK</u>		11. BIRTHPLACE (State or foreign country) <u>PARK HALL WASH. Co. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMSON POFFENBERGER</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN PALMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-30-9941</u>		17. INFORMANT <u>MRS. CHARLES KEFAWKE KEEDYSVILLE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-29-</u> 19 <u>50</u> , to <u>11-28-</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-30-1960</u> , and that death occurred at <u>ASPM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>				22b. DATE SIGNED <u>12/30/60</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph Secondari, M. D.</u>	
22d. ADDRESS <u>21 North Main Street Boonsboro, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED <u>12/30/60</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 31 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. Co. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Post</u>				25a. REC'D BY REGISTRAR <u>JAN 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	



1  
Page 4  
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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VR A15 (4)  
15M 9/59

14455  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
14449  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>15 minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
3. NAME OF DECEASED (Type or print) First <b>FONTAINE</b> Middle <b>GARDNER</b> Last <b>POLLARD</b>		4. DATE OF DEATH Month <b>December</b> Day <b>9</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 9, 1960</b>
9. AGE (In years) <b>15</b> yrs		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hagerstown, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>W. Weir Rollard III</b>		14. MOTHER'S MAIDEN NAME <b>Hildegard Rich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>W. Weir Pollard III</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5</b> DUE TO <b>atelectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Immaturity</b> (c) <b>Incompetent Cervical os</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 9</b> 1960 to <b>Dec 9</b> 1960 that (I) (we) last saw the deceased alive on <b>Dec 9</b> 1960 and that death occurred at <b>12/12/60</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>F. D. Dove Jr.</b> M.D.		22b. DATE SIGNED <b>12/12/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. D. Dove Jr.</b>		22d. ADDRESS <b>214 N. Potomac St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/9/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Franklin Rouse</b>		25a. REC'D BY REGISTRAR <b>DEC 14 '60</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Fennell</b>	

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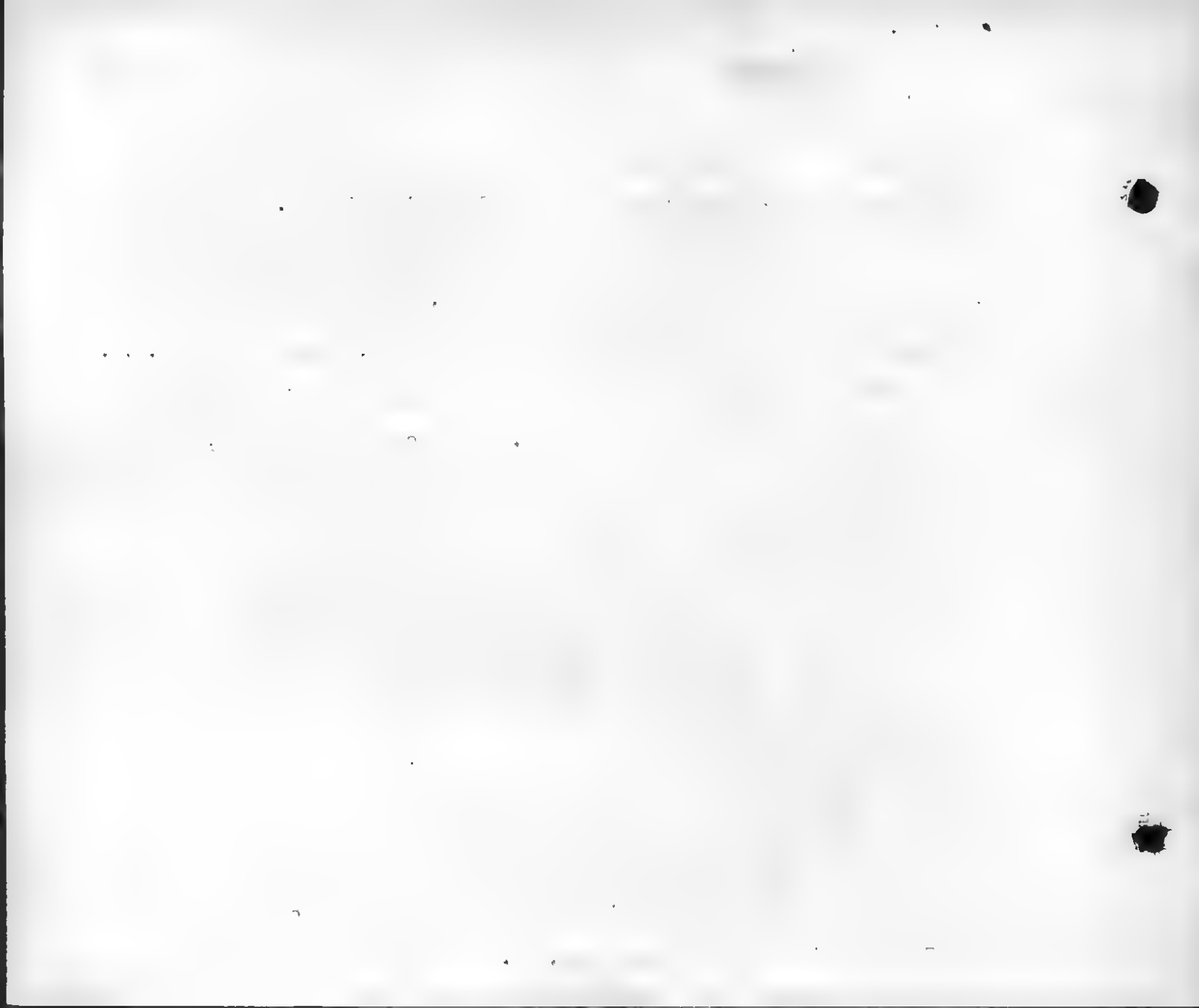


1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

14456

14450

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>most of life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		e. STREET ADDRESS <b>1109 Virginia Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>HESTER</b> Middle <b>M</b> Last <b>POOTS</b>		4. DATE OF DEATH Month <b>DEC</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 11, 1914</b>
9. AGE (In years lost birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Clear Spring, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Allen Repp</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Bruce Reid</b>		Address <b>Big Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CA OF OVARY</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>17 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 30</b> , 19 <b>60</b> , to <b>DEC 5</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>DEC 5</b> , 19 <b>60</b> , and that death occurred at <b>4:30</b> PM, from the causes and on the date stated above			
22a. SIGNATURE <b>Antonio U. Pallagrosi</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLAGROSI</b>		22d. ADDRESS <b>1500 PENNSILANIA AVE. HAGERSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/7/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 9 '60</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William X. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

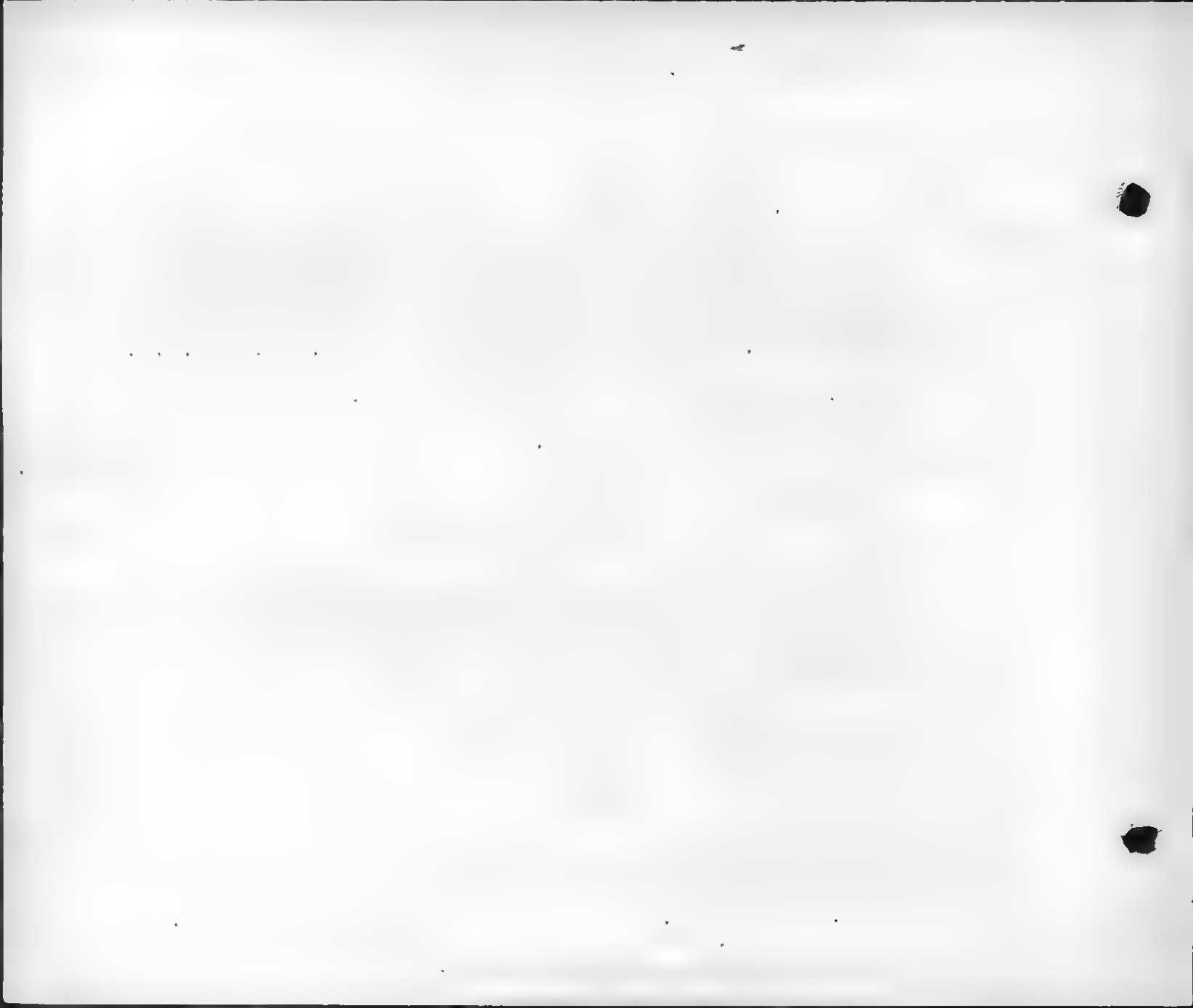
14457

## CERTIFICATE OF DEATH

Reg. Dist. No.

14451

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>14 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Co. Hospital</u>		e. STREET ADDRESS <u>28 Broadway</u>	
3. NAME OF DECEASED (Type or print) First <u>ELMER</u> Middle <u>ELIAS</u> Last <u>RAYMER</u>		f. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1870</u>
9. AGE (In years last birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	11. IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired cabinet lab.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cabinet factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon P. Raymer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Delauter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Irs. Ethel Martin</u>		Address <u>28 Broadway, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 33.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 wks</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>a. p.</u> m. <u>  </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/7, 1960</u> to <u>12/7, 1960</u> , that I last saw the deceased alive on <u>12/7, 1960</u> , and that death occurred at <u>5:30</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Harrison</u>		DATE SIGNED <u>12/8/60</u>	
DECEASED'S NAME (Type) <u>Paul Harrison</u>		<u>Hagerstown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 10, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Myersville, Fred Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittie</u>		24a. REC'D BY REGISTRAR <u>DEC 12 '60</u>	24b. REGISTRAR'S SIGNATURE <u>C. J. S. Thomas</u>



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14458

14453

1 PLACE OF DEATH a. COUNTY Washington MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 14 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. Co. Hospital				d. STREET ADDRESS 218 W. Franklin		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle C Last Riley				4. DATE OF DEATH Month 12 Day 27 Year 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18, 1911	
9. AGE (In years last birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) construction worker				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Ralph Riley				14. MOTHER'S MAIDEN NAME Blanche Swartz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO 579-09-6443		17. INFORMANT Ralph Riley Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia and Pulmonary Edema. DUE TO (b) Benign Prostatic Hypertrophy and bilateral Hydroureter and Hydronephrosis. DUE TO (c) al Hydroureter and Hydronephrosis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 24 hours.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1960 to Dec. 27, 1960, that (I) (we) last saw the deceased alive on Dec. 26, 1960 and that death occurred at 12:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE R.A. Bell				22b. DATE SIGNED Dec. 27, 1960.			
22c. PHYSICIAN'S NAME (Type) R.A. Bell, M.D.				22d. ADDRESS Hagerstown, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 '60	
				25b. REGISTRAR'S SIGNATURE Carlton S. Harris			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

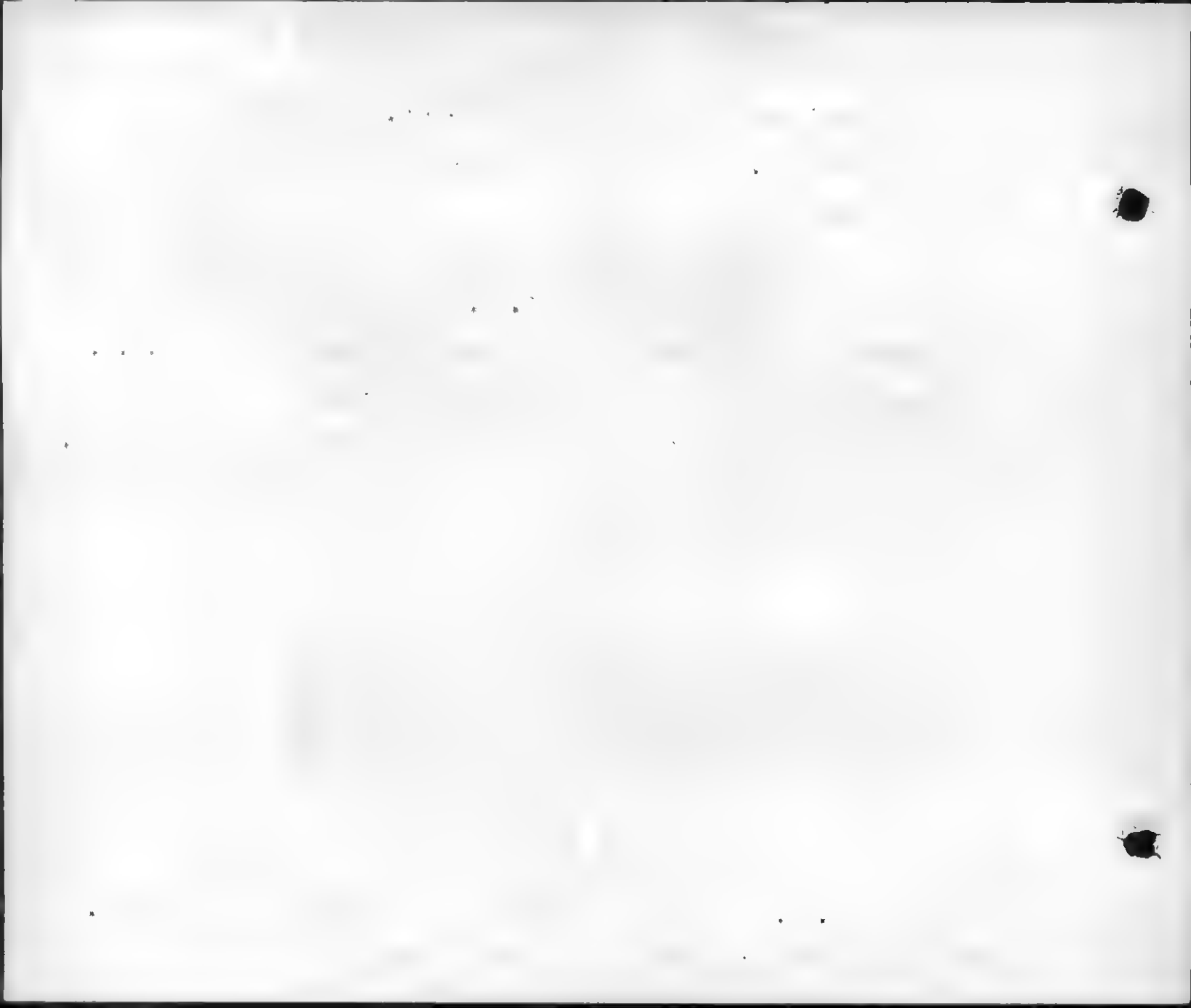
VR A15 (4)  
TSM 9/59

14497

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14454

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Bedford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hancock Md.</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Everett Rural 2</b>		d. STREET ADDRESS <b>75X-2</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maria</b> Middle <b>Jane</b> Last <b>Ritchey</b>		4. DATE OF DEATH Month <b>12</b> Day <b>19</b> Year <b>19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3.12.1870</b>
9. AGE (in years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>19</b> Min <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Bedford County Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Foor</b>		14. MOTHER'S MAIDEN NAME <b>Mary Swartz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs Nellie Exline</b>		Address <b>Rural Hancock Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Colon</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>2 mo</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 18 1960</b> to <b>Dec 19 1960</b> , that (I) <b>last</b> saw the deceased alive on <b>Dec 19 1960</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. M. Shaffer</b>		22b. DATE SIGNED <b>DEC 23 '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Hancock Md.</b>		22d. ADDRESS <b>L. M. SHAFER</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12.22.60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Bedford County Penna.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Houard J. Stone</b>		25a. REC'D BY REGISTRAR <b>DEC 23 '60</b>	
ADDRESS <b>Hancock Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

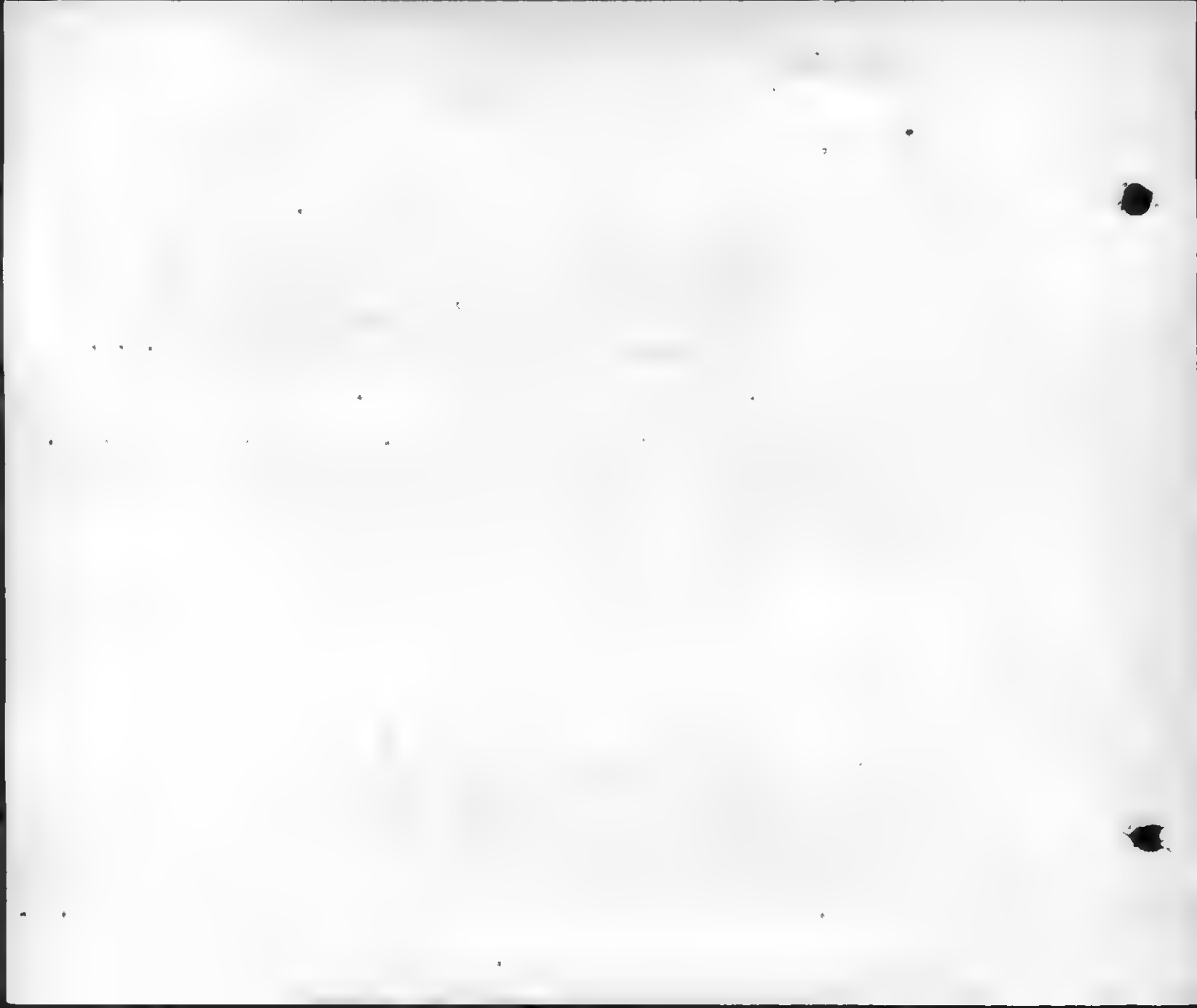
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14459

14455

1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b>			
d. STREET ADDRESS <b>17 East Second St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mina</b> Middle <b>Mae</b> Last <b>ROGER</b>				4. DATE OF DEATH Month <b>DEC</b> Day <b>17</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1915</b>	
9. AGE (In years last birthday) <b>45 yrs</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>		11. IF UNDER 24 HRS Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Magnetic Devices</b>		11. BIRTHPLACE (State or foreign country) <b>Emmitsburg, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William R. Roger</b>				14. MOTHER'S MAIDEN NAME <b>Fannie G. Ashbaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-16-1937</b>		17. INFORMANT Address <b>Mrs. Edger L. Robinson, Thurmont, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PERITONITIS</b> <b>153-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PERFORATION OF COLON</b> DUE TO (c) <b>CARCINOMA OF HEPATIC FLEXURE UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>NOV 18, 1960</b> , to <b>DEC 17, 1960</b> , that (I) (we) last saw the deceased alive on <b>DEC 17, 1960</b> , and that death occurred at <b>10:45 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Antonio U. Palladrosi</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLADROSI</b>				22d. ADDRESS <b>1500 PENNA. AVE. HAGERSTOWN</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 21, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Frederick, Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Wilson</b>				ADDRESS <b>Emmitsburg, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 22 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>C. E. Wilson</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/59

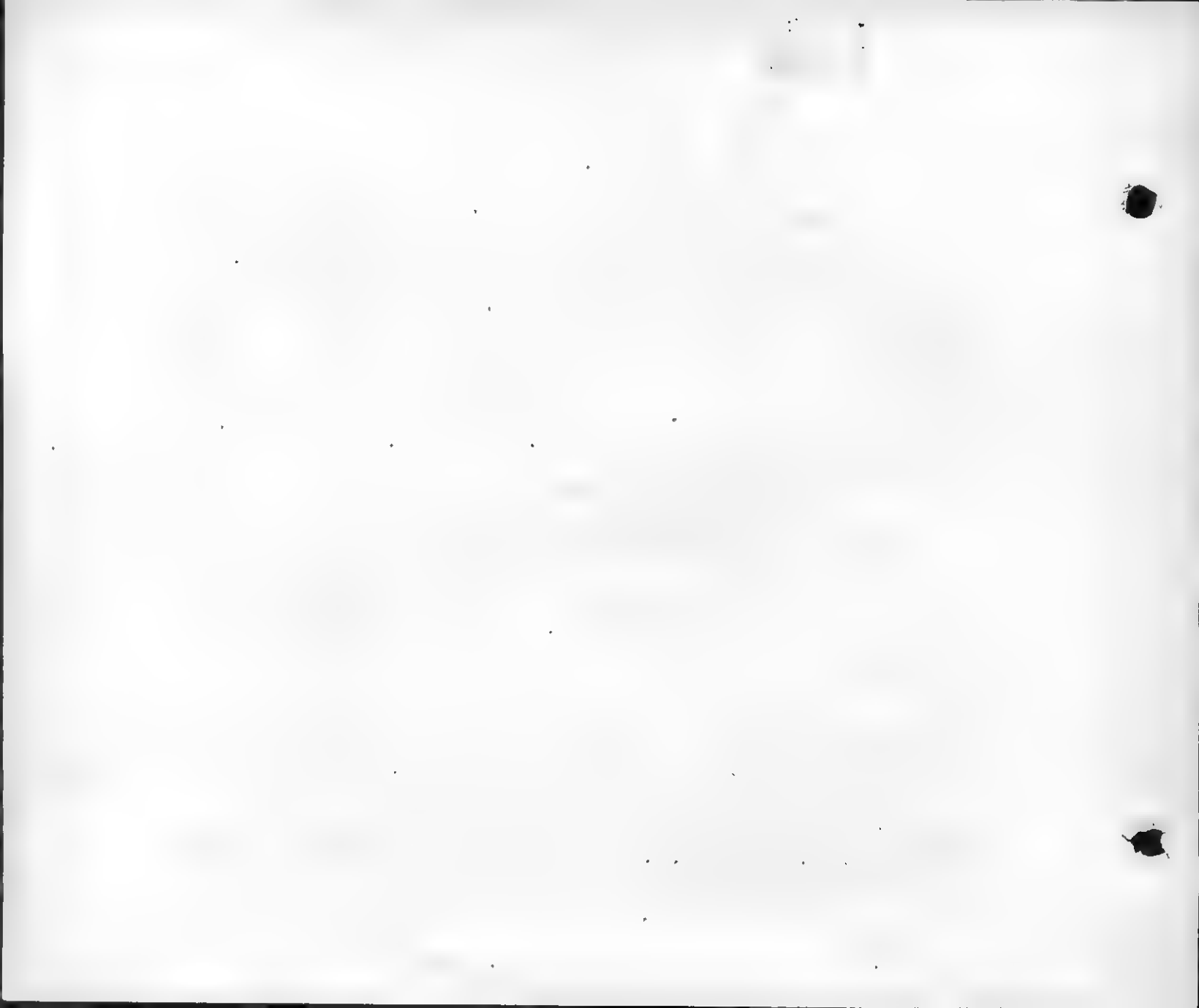
14460

14456

14460

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Convalescent Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
				d. STREET ADDRESS <u>Rt. 5 Hagerstown Maryland</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>REBECCA</u> Last <u>ROHRER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1960</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1859</u>		9 AGE (In years last birthday) <u>101</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11 BIRTHPLACE (State or foreign country) <u>Funkstown</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Helferstay</u>				14. MOTHER'S MAIDEN NAME <u>Patsy Creager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>Mr. Robert R. Rohrer</u>		Address <u>Rt. #5 Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 3 1/2 years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis.</u> Years							
(c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>							
19 WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>July 5, 1957</u> to <u>Dec. 18, 1960</u> that (I) (we) last saw the deceased alive on <u>Dec. 18, 1960</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above							
22a SIGNATURE <u>R. A. Bell</u>				22b DATE SIGNED <u>12-19-60</u>			
22c PHYSICIAN'S NAME (Type) <u>R. A. Bell, M.D.</u>				22d. ADDRESS <u>Hagerstown, Maryland.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>12-30-60</u>		23c NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				25a REC'D BY REGISTRAR <u>DEC 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Finney</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

14461

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14457

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 935 Fairfield Road				d. STREET ADDRESS 1 935 Fairfield Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Laura Ann Sealy				4. DATE OF DEATH Month Day Year December 21 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17, 1874	9. AGE (in years last birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Walhall Miss.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William H. H. Hull				14. MOTHER'S MAIDEN NAME Mary Ann Peoples			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Merritt A. Digelow Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio ne nephrosclerosis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 mo-						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Oct. 1, 1960 to Dec. 21, 1961, that (I) (we) last saw the deceased alive on Dec. 21, 1961, and that death occurred at 6:30 M. from the causes and on the date stated above							
22a. SIGNATURE Doyd A. Hoffman		M. D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Doyd A. Hoffman		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE THEREOF 12-23-60		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Oklahoma City Okla.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 31 '60	
				25b. REGISTRAR'S SIGNATURE Arthur P. House			

MEDICAL CERTIFICATION



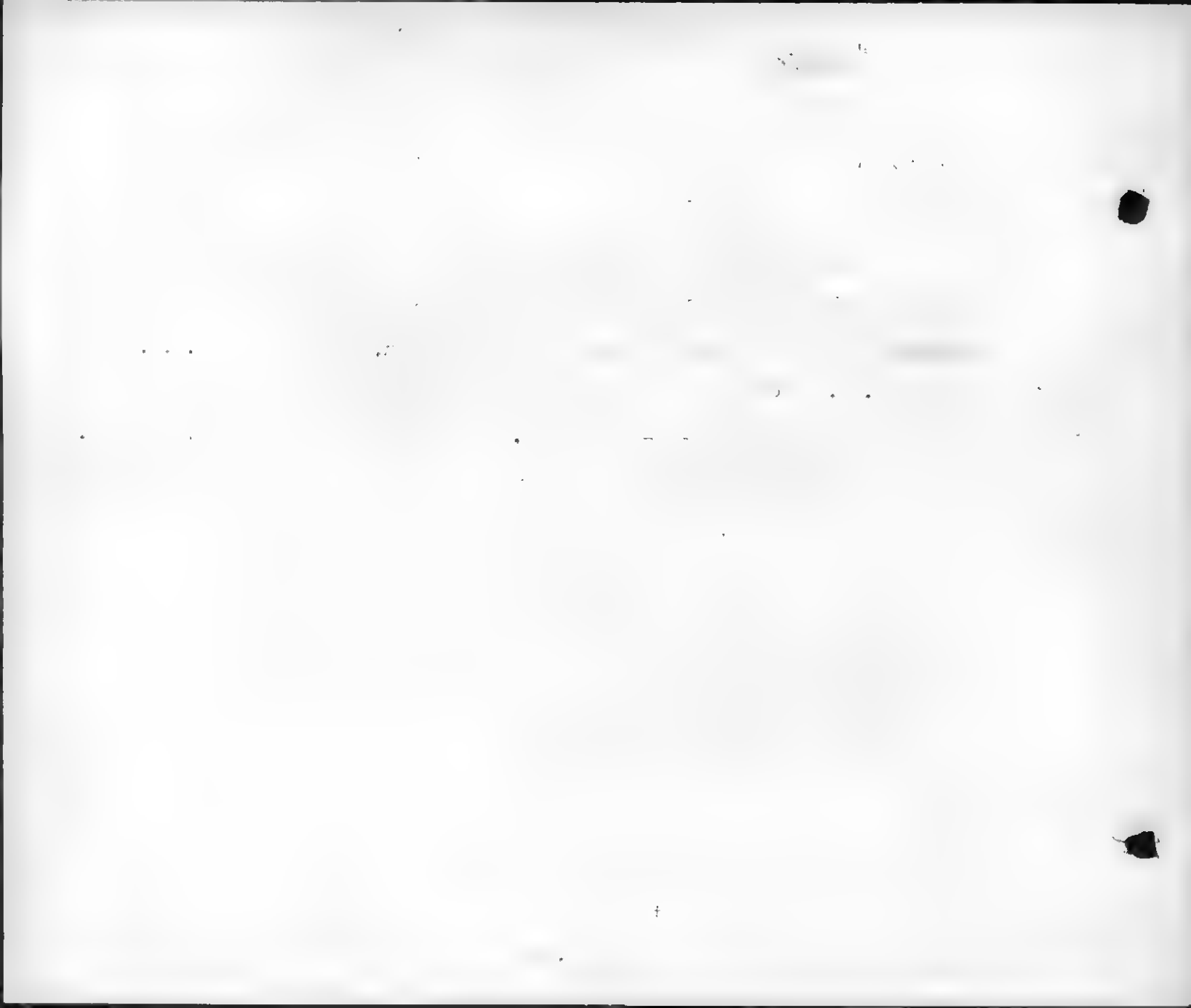
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14462

CERTIFICATE OF DEATH

14458

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. STREET ADDRESS <b>45 North Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>CECILE</b> Middle <b>ROACH</b> Last <b>SEIBERT</b>		4. DATE OF DEATH Month <b>December</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31, 1897</b>
9. AGE (in years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR: Months <b>63</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis A. B. Roach</b>		14. MOTHER'S MAIDEN NAME <b>Mary Good</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>218-30-8619</b>	
17. INFORMANT <b>Mrs. Alice Reynolds</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Vasc. Disease</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 yrs. +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 5</b> , 1960, to <b>Dec. 21</b> , 1960, that (I) <b>(was)</b> last saw the deceased alive on <b>Dec. 21</b> , 1960 and that death occurred at <b>2 P.</b> M. from the causes and on the date stated above			
22a. SIGNATURE <b>Lloyd A. Hoffmann</b> M.D.		22b. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffmann</b>		22d. ADDRESS <b>Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/23/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>A. Franklin Rouzer</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14459

Reg. Dist. No.

14498

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Sharpsburg		c. LENGTH OF STAY IN 1b 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sharpsburg RFD #1		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) * (Rural) Sharpsburg Md. RFD #1	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mamie Louise Shafer		4. DATE OF DEATH Month Day Year Dec. 9 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21 1916
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dairy maid	11. BIRTHPLACE (State or foreign country) Downsville Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Ira Shafer		14. MOTHER'S MAIDEN NAME Cora Putman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 30 9049	
17. INFORMANT Mr. Charles Shafer		Address Shepherdstown W. Va	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation due to drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) 978X			INTERVAL BETWEEN ONSET AND DEATH Unusual
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Depressed - jumped into water	
20c. TIME OF INJURY Month, Day, Year Hour, o. m. Dec 9, 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Sharpsburg Wash Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Edward W. Ditto III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/19/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Earl L. Leaf		24a. REC'D BY REGISTRAR DEC 13 '60	
ADDRESS Williamport Md		24b. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

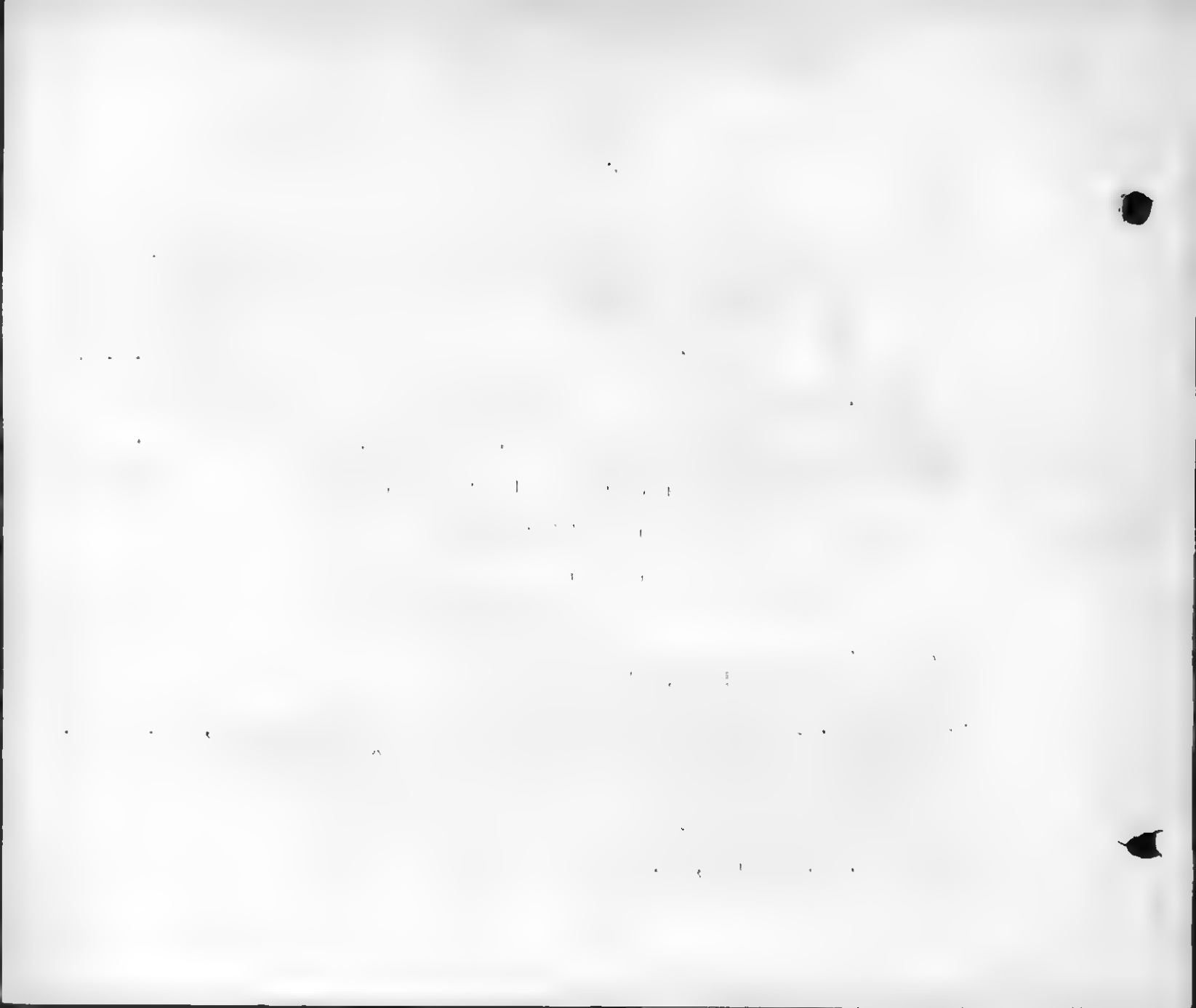
1449.9 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 920 VIEW ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SECURITY				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last PHILIP HUYETT SHANK				4. DATE OF DEATH Month Day Year DECEMBER 30 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/1947		9. AGE (In years last birthday) 13 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY JR. HIGH SCHOOL		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT H. SHANK				14. MOTHER'S MAIDEN NAME MADILENE SPICKLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT MR. ROBERT H. SHANK			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF LEFT CHEST DUE TO PENETRATING LEFT LUNG AND HEART Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO HEMOPERICARDIUM AND HEMOTHORAX (c)				INTERVAL BETWEEN ONSET AND DEATH INSTANT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ACCIDENTALLY SHOT IN BACK					
20c. TIME OF INJURY Month, Day, Year 1:10 p. m. DEC. 30 60		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg. etc.) FARM		20f. (City or town) (County) (State) HAGERSTOWN, MD. WASH.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) DR. E.W. DITTO, JR.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/2/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/2/61		22c. NAME OF CEMETERY OR CREMATORY BEST HAVEN CEM		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horneat, Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE JAN 4 '61		24b. REGISTRAR'S SIGNATURE Charles S. Knecht	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> c. LENGTH OF STAY IN 1b <u>19 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHARPSBURG MD. R.F.D.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL</u> d. STREET ADDRESS <u>SHARPSBURG MD. R.F.D.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN HENRY SHIMP</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month <u>DECEMBER</u> Day <u>26</u> Year <u>1936</u>	
9. AGE (In years) (If under 1 year: If under 24 hrs.) Months <u>11</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>JANES SPRINGS W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM SHIMP</u>		14. MOTHER'S MAIDEN NAME <u>ELSIE WEAVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>LESTER SHIMP. SHARPSBURG MD.</u>	
17. INFORMANT <u>LESTER SHIMP. SHARPSBURG MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Freezing General</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Simple Fracture 5,6,7,8,9th. Ribs (Left)</u> DUE TO (c) <u>Laceration Of Scalp.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>11-11-1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 or 2 hours</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Driving farm tractor missed road capsized pinning driver beneath tractor.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> p.m. <u>12-12-1960</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) (County) (State) <u>Sharpsburg, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. J. Ditto, Jr.</u>		M.D.	
EXAMINER'S NAME (Type) <u>Dr. E. J. Ditto, Jr.</u>		DATE SIGNED <u>12-14-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 15 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GREENLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>WILLIAMSPORT MD</u>	
23. FUNERAL DIRECTOR <u>John D. Best</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 21 '60</u>		24b. REG STRAR'S SIGNATURE <u>Arthur L. Huns</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14480

14463

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hedgesville Route #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>75</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James R. Shriver</u>		4. DATE OF DEATH Month Day Year <u>December 20 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28 1879</u>
9. AGE (In years lost birthday) <u>81</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Berkeley Co. West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Shriver</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emma Donaldson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>James O. Shriver</u> Address <u>Hedgesville Rt. # 1 West Va.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
450.0 DUE TO (b) <u>Generalized Atherosclerosis</u>		5 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1958</u> to <u>12-19</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>12-19</u> 19 <u>60</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>M. E. Byrkit</u>		22b. DATE SIGNED <u>12-20-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>		22d. ADDRESS <u>28 W Potomac Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-23-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hedgesville Rt. # 2, W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>		25a. REC'D BY REGISTRAR <u>DEC 23 '60</u>	
ADDRESS <u>Martinsburg, W. Va.</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Hume</u>	





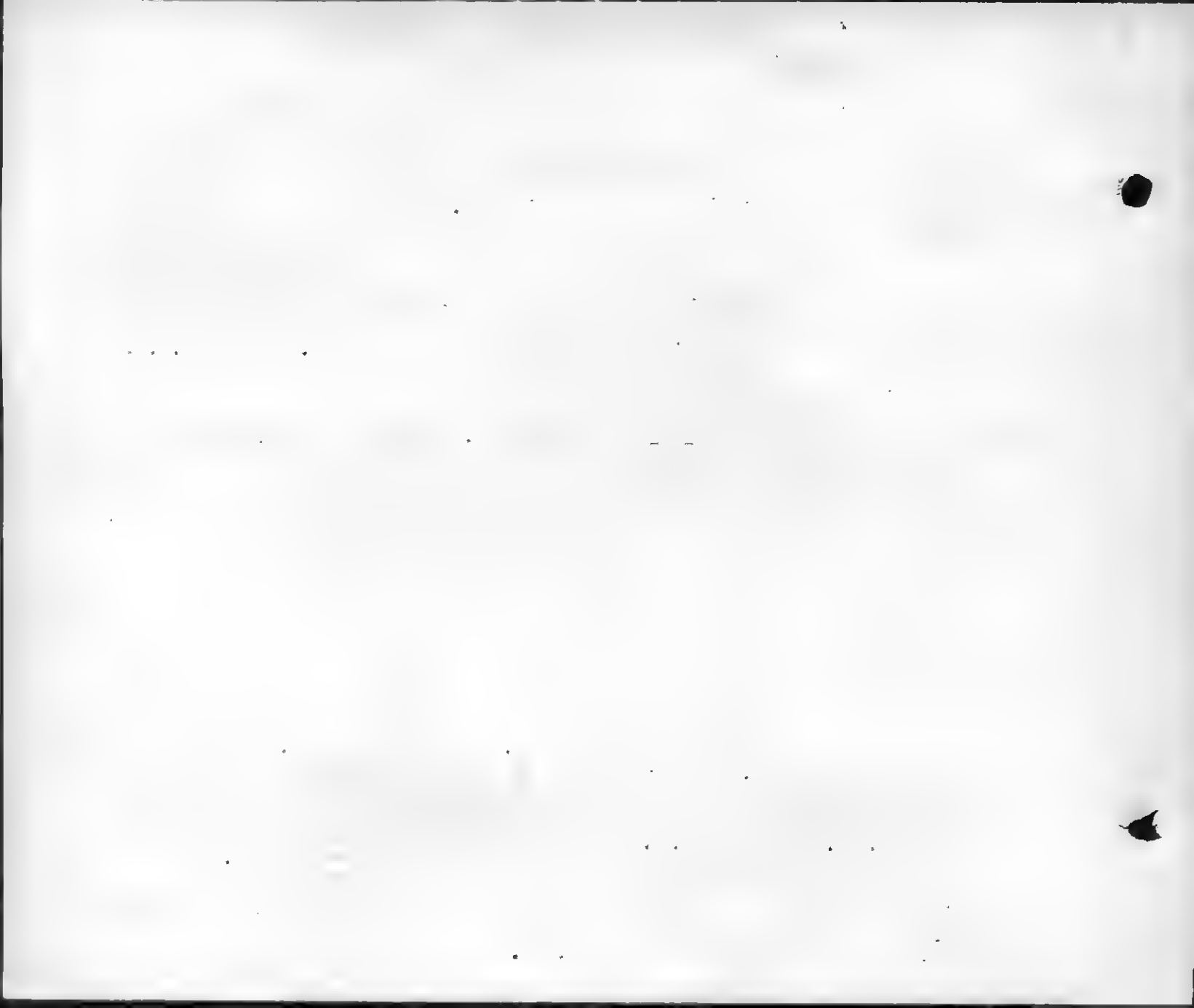
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

14463

14464

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>44 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WILLIAM</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1881</b>		9. AGE (In years last birthday) <b>79 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Furniture Company</b>		11. BIRTHPLACE (State or foreign country) <b>New Oxford, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon Charles Smith</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Staley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-2503</b>		17. INFORMANT <b>Lester R. Smith</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septal Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>Indeterminate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lobular Atelectasis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 25, 1960</b> to <b>Dec. 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 3, 1960</b> and that death occurred at <b>5:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Layman, M.D.</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <b>5 Public Square Hagerstown, Md.</b>		22b. DATE SIGNED <b>12-5-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/6/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Berger</i>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 9 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

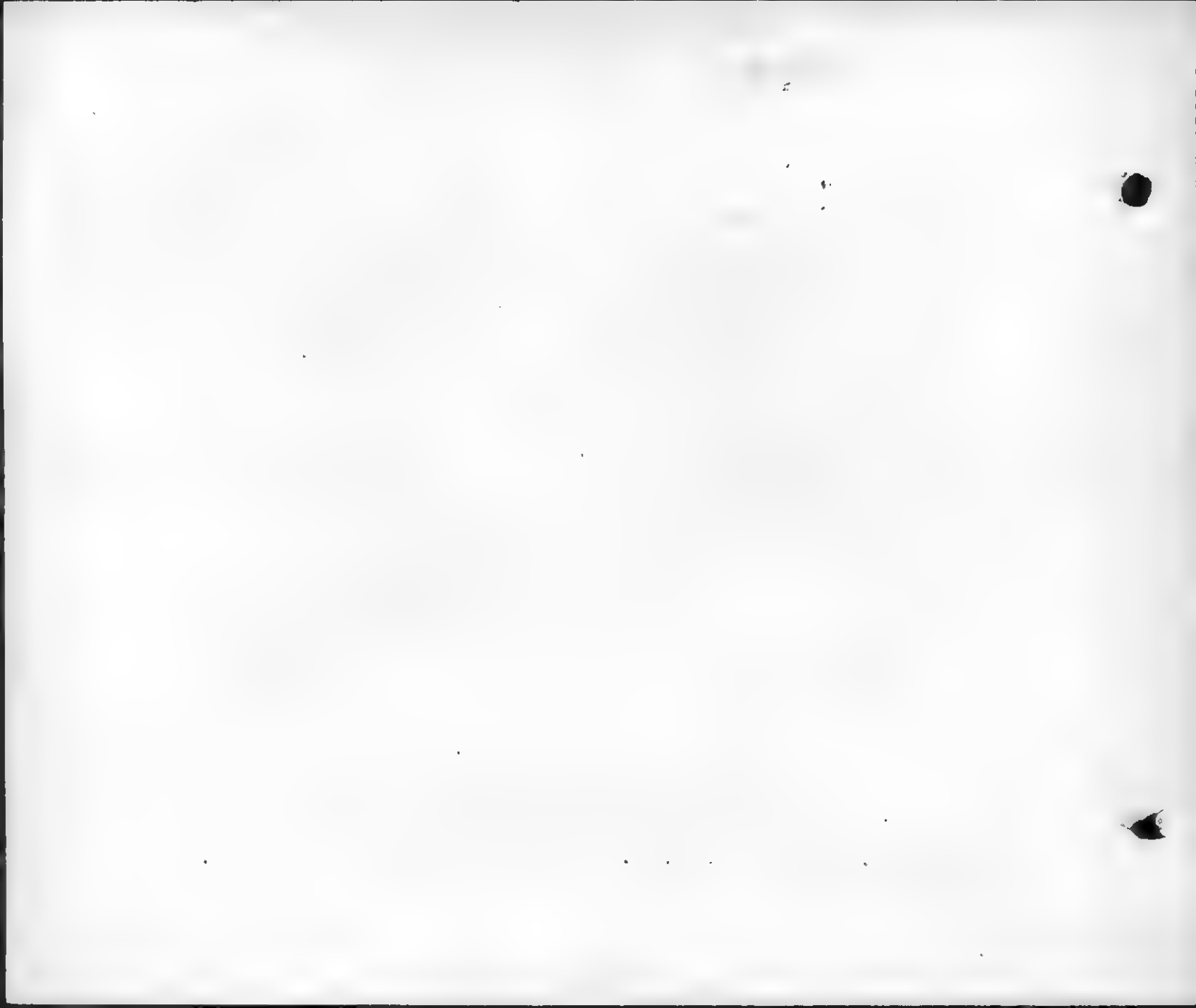
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14464

14465

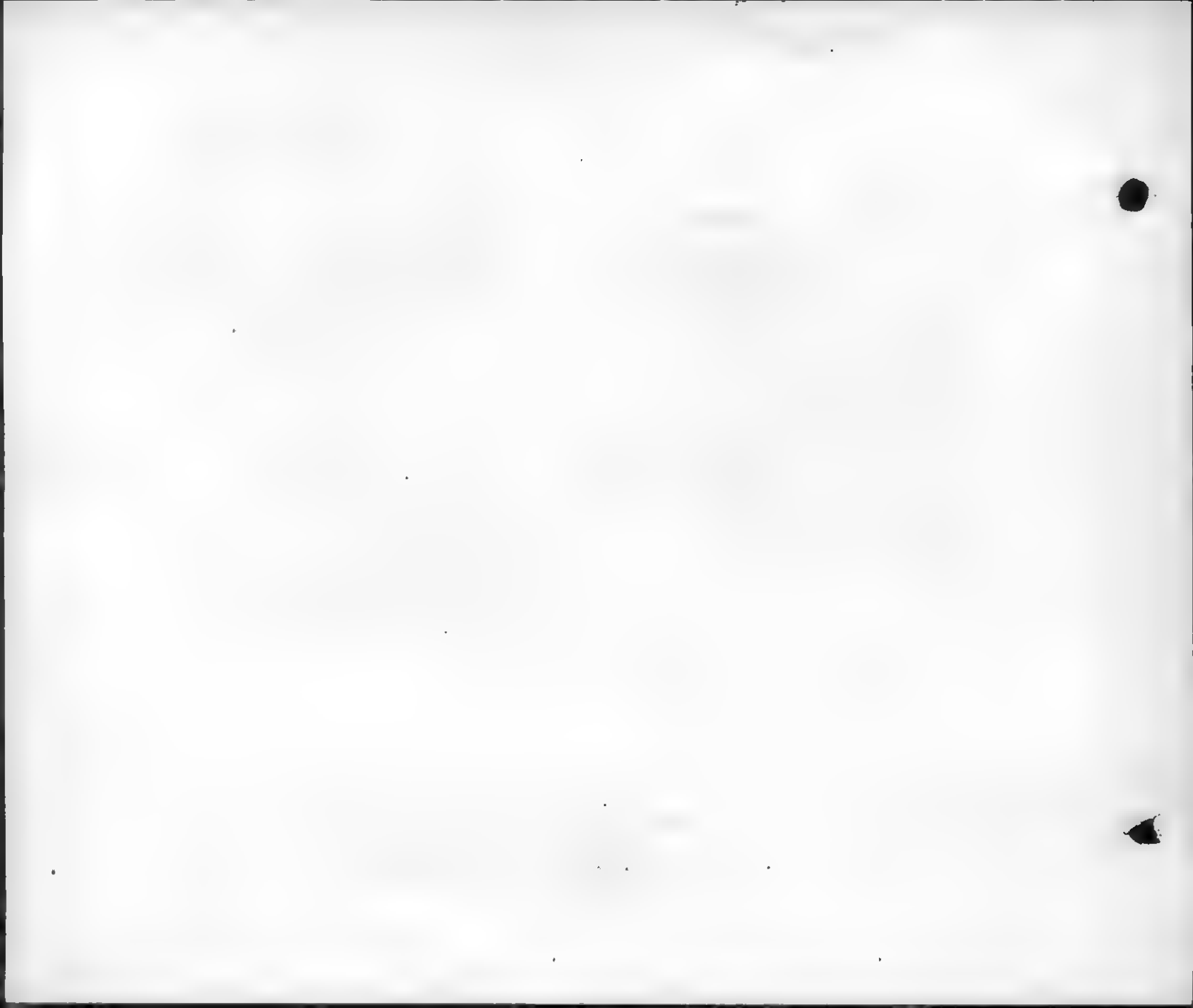
1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Wayside Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Catherine Snyder		4. DATE OF DEATH Month Day Year December 8 1960	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1898
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington Co. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Parr		14. MOTHER'S MAIDEN NAME Margaret Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Edward T. Snyder		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 345A Stomach - due to aspiration DUE TO (b) of Vomitus - DUE TO (c) Multiple Sclerosis INTERVAL BETWEEN ONSET AND DEATH 15 yrs		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Aug 1, 1960 to Dec 8, 1960, that (I) (we) last saw the deceased alive on Nov 2, 1960, and that death occurred at 4 PM, from the causes and on the date stated above			
22a. SIGNATURE Edward W. Ditto III		22b. DATE 12/9/60	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-11-60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REG STRAR DATE DEC 12 '60	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Farris	



1  
TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

<div style="display: flex; justify-content: space-between;"> <div> <div>14465</div> <div>Item 4 FilmG276 12-10-60 et</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> </div> <div> <div>14466</div> <div>302</div> </div> </div>													
<b>1 PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>6 Days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash County Hospital</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>428 Summit Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>CHARLES EDGAR SPRECHER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>December 4, 1960</u>									
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept 10 1876</u>		<b>9. AGE</b> (In years lost birthday) <u>84</u> yrs		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS</b> Hours Min	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>---</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Daniel Sprecher</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Ann Miller</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO</b> <u>None</u>		<b>17. INFORMANT</b> Address <u>Mrs Catherine Taylor Williamsport Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate Gland</u> R # 2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1777X</u> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 1/2 years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Atherosclerosis, Vessels Aortic Arch, Aorta, Peripheral Vessels</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2-6-</u> <u>1953</u> <b>to</b> <u>12-4-</u> <u>1960</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>12-4-</u> <u>1960</u> , <b>and that death occurred at</b> <u>4:00 P.</u> <b>M, from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>Dalton M. Welty</u> M.D.						<b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Dalton M. Welty, M.D.</u>						<b>22d. ADDRESS</b> <u>998 Potomac Ave., Hagerstown, Md.</u>							
<b>23a. BURIAL, CREMATON, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>12/7/60</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>				<b>23d. LOCATION (City, town, or county)</b> (State) <u>Hagerstown Wash Co Md</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>						<b>ADDRESS</b> <u>Hagerstown Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DEC 12 60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William L. Frank</u>			



1  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14466

14467

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
c. LENGTH OF STAY IN 1b <u>1 hour</u>				d. STREET ADDRESS <u>123 S. Vermont St. 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lloyd William Stevens</u>				4. DATE OF DEATH Month <u>12</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-1905</u>	9. AGE (In years last birthday) <u>55</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Forman at Fairchild Aircraft</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. McClannahan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-03-6341</u>		17. INFORMANT Address <u>123 Vermont St. Williamsport Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420. Ventricular fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>3 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> 19 <u>57</u> to <u>Dec 3</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Dec 2</u> 19 <u>60</u> and that death occurred at <u>1:25</u> M. from the causes and on the date stated above							
22a. SIGNATURE <u>ME Byrkit</u>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ME Byrkit</u>				22d. ADDRESS <u>28 W Potomac Wmspt Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery Williamsport Md.</u>		23d. LOCAT ON (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J Stone Williamsport Md</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	
				DATE <u>DEC 8 '60</u>			





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14467

14468

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>50 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>433 Clarendon Ave.</b>				d. STREET ADDRESS <b>433 Clarendon</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF (Type or print) First Middle Last <b>LUTHER McLINN STONER</b>				4. DATE OF DEATH Month Day Year <b>Dec. 8, 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 7, 1884</b>	
9. AGE (In years lost birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Iron works</b>		11. BIRTHPLACE (State or foreign country) <b>Union Bridge, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Albert Stoner</b>				14. MOTHER'S MAIDEN NAME <b>Emma Catherine Rodgers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-3782</b>		17. INFORMANT Address <b>Luther A. Stoner 433 Clarendon Ave. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Right Sided Hemiplegia due to cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>General arteriosclerosis</b> (b) <b>General arteriosclerosis</b> (c) <b>General arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Benign prostate hypertrophy</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>5 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1, 1960</b> to <b>Dec 8, 1960</b> , that (I) (we) last saw the deceased alive on <b>Nov 20, 1960</b> , and that death occurred at <b>4:45 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward W. Dittus, Jr.</b>				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12/9/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Dittus, Jr.</b>				22d. ADDRESS <b>217 W. Washington St Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/11/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. A. Horst</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 12 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kraw</b>			



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

14468

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14470

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. Md. State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Norma Jane</u> Middle <u>Sword</u> Last <u>Sword</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 17 1880</u>	
9. AGE (In years last birthday) yrs <u>80</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thornton Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Lary C. Rapple</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James M. Sword Jr Hagerstown Md</u> <u>Rt 3 Walnut Pt Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Perinephritic abscess, left</u> DUE TO (b) <u>Pyonephrosis, left</u> DUE TO (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>About 5 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobular Pneumonia, bilateral</u>				19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 7 1958</u> to <u>Dec. 28 1960</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 28 1960</u> and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u> M.D.				22b. DATE SIGNED <u>Dec. 28 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Young E. Chun</u>				22d. ADDRESS <u>1500 Penna. Ave. Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Williamsport Wash Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				25a. REC'D BY REGISTRAR <u>DEC 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>W. S. Frank</u>	

Andrew K. Coffman Hager town Md.

2

2

14469

## CERTIFICATE OF DEATH

Reg. Dist. No.

14471

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>17 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) - a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u> d. STREET ADDRESS <u>HAGERSTOWN MD. R. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>QUINTER</u> Middle <u>E.</u> Last <u>VALENTINE</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 25 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE FLOUR MILL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAVETOWN WASH. CO. MD. U.S.A</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>REUBEN VALENTINE</u>		14. MOTHER'S MAIDEN NAME <u>MARY STULL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-7032</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 3x1X DUE TO <u>Glomerulo-nephrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Severe's got extra kidneys</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days -</u> <u>7 years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> a. m. <u></u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1, 1960</u> , to <u>December 4, 1960</u> , that I last saw the deceased alive on <u>December 4, 1960</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Secondari</u>		ADDRESS (Street, city or town, state) <u>21 North Main Street</u> DATE SIGNED <u>12/4/60</u>	
PHYSICIAN'S NAME (Type) <u>Joseph Secondari</u>		<u>Boonsboro, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 6 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FAHARREYS CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>SAN MAR WASH. CO. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		24a. REC'D BY REGISTRAR <u>DEC 13 '60</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. S. Kinn</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 11/59

1  
MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
14470  
14473  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>1487 Mitchell Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>GROVER</b> First <b>CLEVELAND</b> Middle <b>VAUGHN</b> Last		4. DATE OF DEATH Month <b>December</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 5, 1891</b>
9 AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
11 BIRTHPLACE (State or foreign country) <b>Luray, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Vaughn</b>		14. MOTHER'S MAIDEN NAME <b>Allie Henry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>219-14-8338</b>	
17. INFORMANT <b>Mrs. Edith Vaughn</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary (myocardial infarction)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b> DUE TO (c) <b>As - years</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>12/28/60</b> to <b>12/14/60</b> , 19 <b>11:30 PM</b> , that (I) (we) last saw the deceased alive on <b>12/14/60</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward N. Weeks, M.D.</b>		22b. ADDRESS <b>136 N. Potomac St., Hagerstown, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward N. Weeks, M.D.</b>		22d. ADDRESS <b>136 N. Potomac St., Hagerstown, Md.</b>	
23a. BLR AL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/17/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Franklin Rouzer</b>		25a. REC'D BY REG STRAR DATE <b>DEC 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. L. S. Tuma</b>			





TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

14471

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

14473

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>11048 Corbett Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ROSE</b> Last <b>WAGNER</b>		4. DATE OF DEATH Month <b>December</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1896</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Knodle</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor W. Wagoner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mr. George I. Wagner</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(1) Chronic bronchitis, (2) adenocarcinoma, cecal 10 years ago</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-8-28</b> to <b>death</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-24-60</b> , 19____, and that death occurred at <b>2:55 PM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Robert F. Keadle</b>		22b. DATE SIGNED <b>December 12,</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>		22d. ADDRESS <b>Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/13/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rozuser Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE DEC 14 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>C. S. S. S. S.</b>			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be used by the attending physician and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND															
14472 CERTIFICATE OF DEATH 303 14472															
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>143 No Jonathan St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>TOLLIVER</u> Last <u>WATSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>7</u> Year <u>1960</u>				5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 13 1893</u> 9. AGE (In years lost, birthday) <u>37</u> yrs 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>15</u> 11. IF UNDER 24 HRS Hours <u>3</u> Min <u>45</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>				11. BIRTHPLACE (State or foreign country) <u>Elkton Rockingham Co Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Cabbage</u>				14. MOTHER'S MAIDEN NAME <u>Annie Willis</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Mrs Elon Rhodes Harrisonburg Va.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>Arteriosclerotic heart disease</u> 420.0 DUE TO (b) <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>---</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 day 3 1/2 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis - healed</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md.</u>				21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2 1960</u> to <u>Dec 7 1960</u> that (I) (we) last saw the deceased alive on <u>Dec 6 1960</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above											
22a. SIGNATURE <u>Philip J. Hirshman</u>				22b. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>				22c. DATE <u>12/7/60</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/9/60</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Newtown Cemetery</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				24a. REC'D BY REGISTRAR <u>DEC 8 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

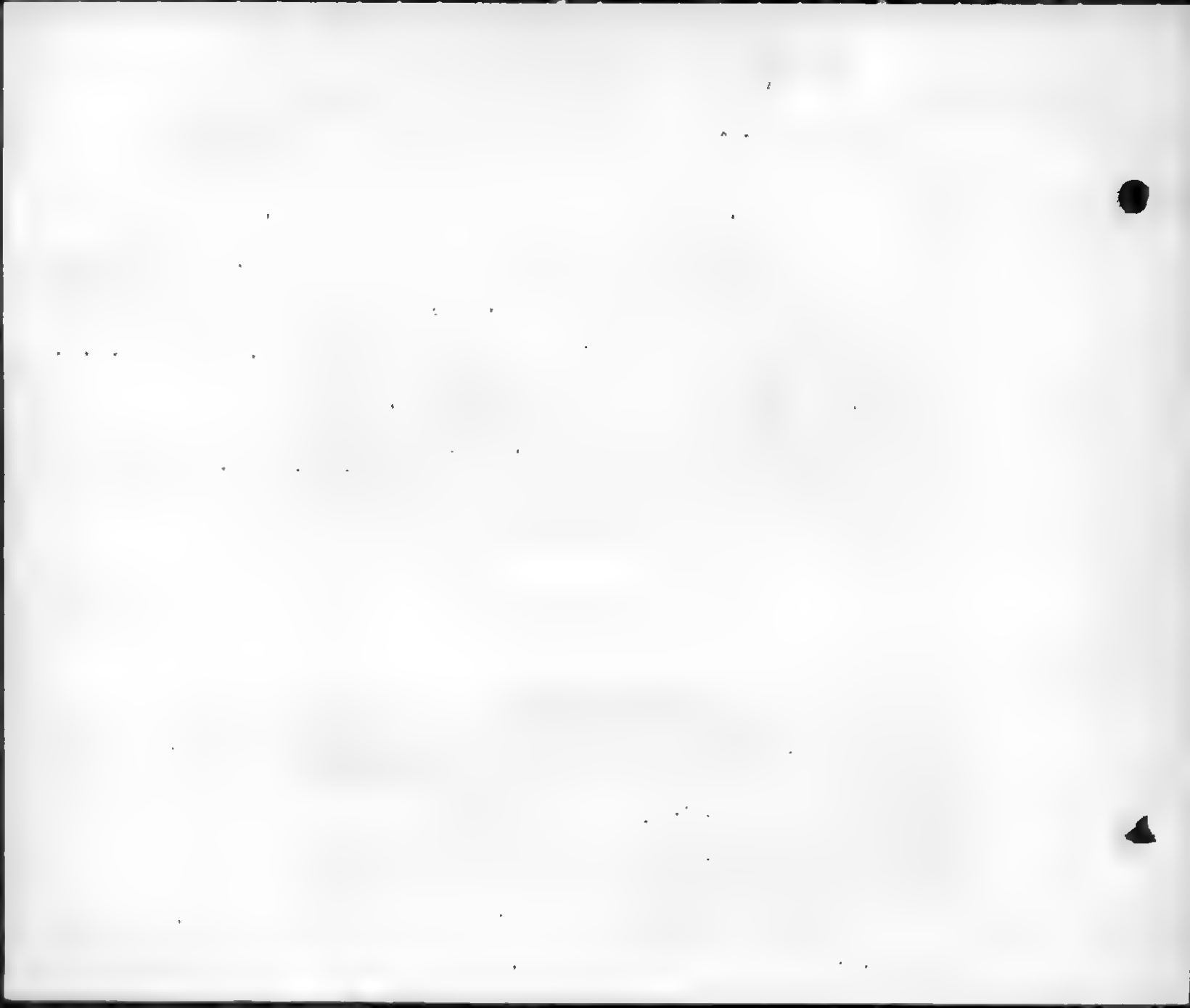
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144775

144773

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>46 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>872 Mulberry Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>Anna Viola Weller</u>				4. DATE OF DEATH Month Day Year <u>Dec. 24 1960</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Broadfording, Wash. Cty., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Sprinkle</u>				14. MOTHER'S MAIDEN NAME <u>Anna C. Good</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Edna Harbaugh, 872 Mulberry Ave Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Generalized</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>yrs.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14 1960</u> to <u>Dec. 24 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24 1960</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>				22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/27/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 14476 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14476

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>7 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>RT. #1 HAGERSTOWN</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WELLS</b> Last <b>WELLS</b>				4. DATE OF DEATH Month <b>DECEMBER</b> Day <b>28</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1899</b>		9. AGE (In years last birthday) <b>61</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHEET METAL WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		11. BIRTHPLACE (State or foreign country) <b>DELEWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY WELLS</b>				14. MOTHER'S MAIDEN NAME <b>EMMA WELLS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. HENRY WELLS</b>		Address <b>RT. #1 HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434</b> IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, RIGHT, RECENT</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4</b> <b>CORONARY ATHEROSCLEROSIS, SEVERE</b> DUE TO <b>CARDIAC HYPERTROPHY</b> (c)							INTERVAL BETWEEN ONSET AND DEATH <b>RECENT</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. W. DITTO, JR.</b>				DATE SIGNED <b>12/28/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/31/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. T. Norman</i>				ADDRESS <i>Hagerstown Md.</i>		24a. REC'D BY REGISTRAR <b>DATE JAN 3 '61</b>	
						24b. REGISTRAR'S SIGNATURE <i>Carroll S. Hume</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card from this certificate and place it in the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

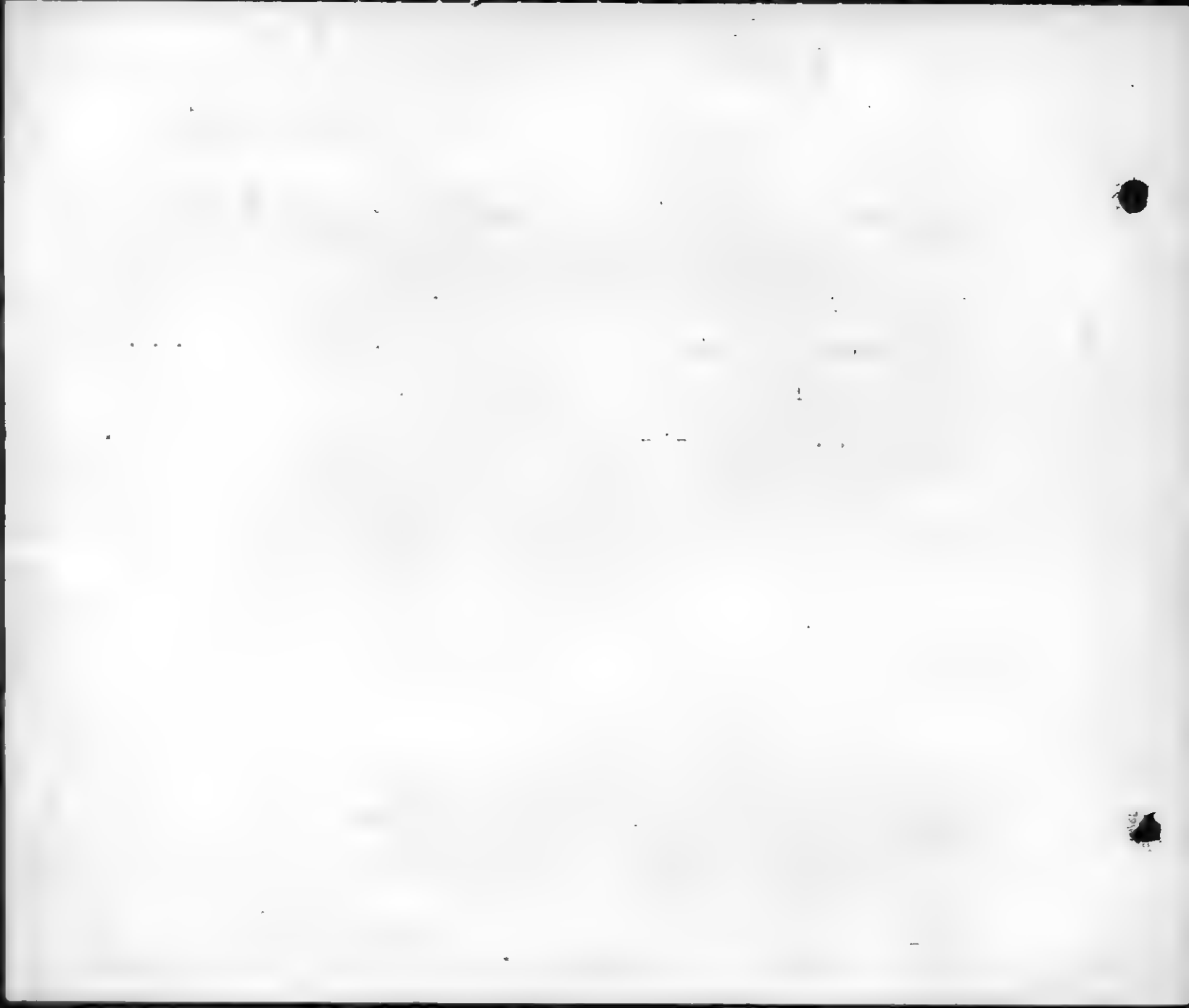
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14475

## CERTIFICATE OF DEATH

14473

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>			d. STREET ADDRESS <b>9 North Potomac Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Franklin</b> Last <b>WELSH</b>			4. DATE OF DEATH Month <b>12</b> Day <b>23</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 22, 1890</b>		9. AGE (In years last birthday) <b>70</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Welsh</b>		
14. MOTHER'S MAIDEN NAME <b>Nettie Boward</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W.I</b>		
16. SOCIAL SECURITY NO. <b>214-09-8153</b>			17. INFORMANT <b>Richard Russell Hagers</b> Address <b>Baltimore, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Coronary atherosclerosis, severe</b> DUE TO (c) <b>Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 25, 1960</b> to <b>Dec. 23, 1960</b> , that (I) (we) last saw the deceased alive on <b>Dec. 23, 1960</b> , and that death occurred at <b>5:40</b> AM, from the causes and on the date stated above.					
22a. SIGNATURE <b>Young E. Chun</b> M.D.		22b. DATE SIGNED <b>Dec. 23-1960</b>		22c. PHYSICIAN'S NAME (Type) <b>Young E. Chun, M.D.</b>	
22d. ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>		22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12/27/1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

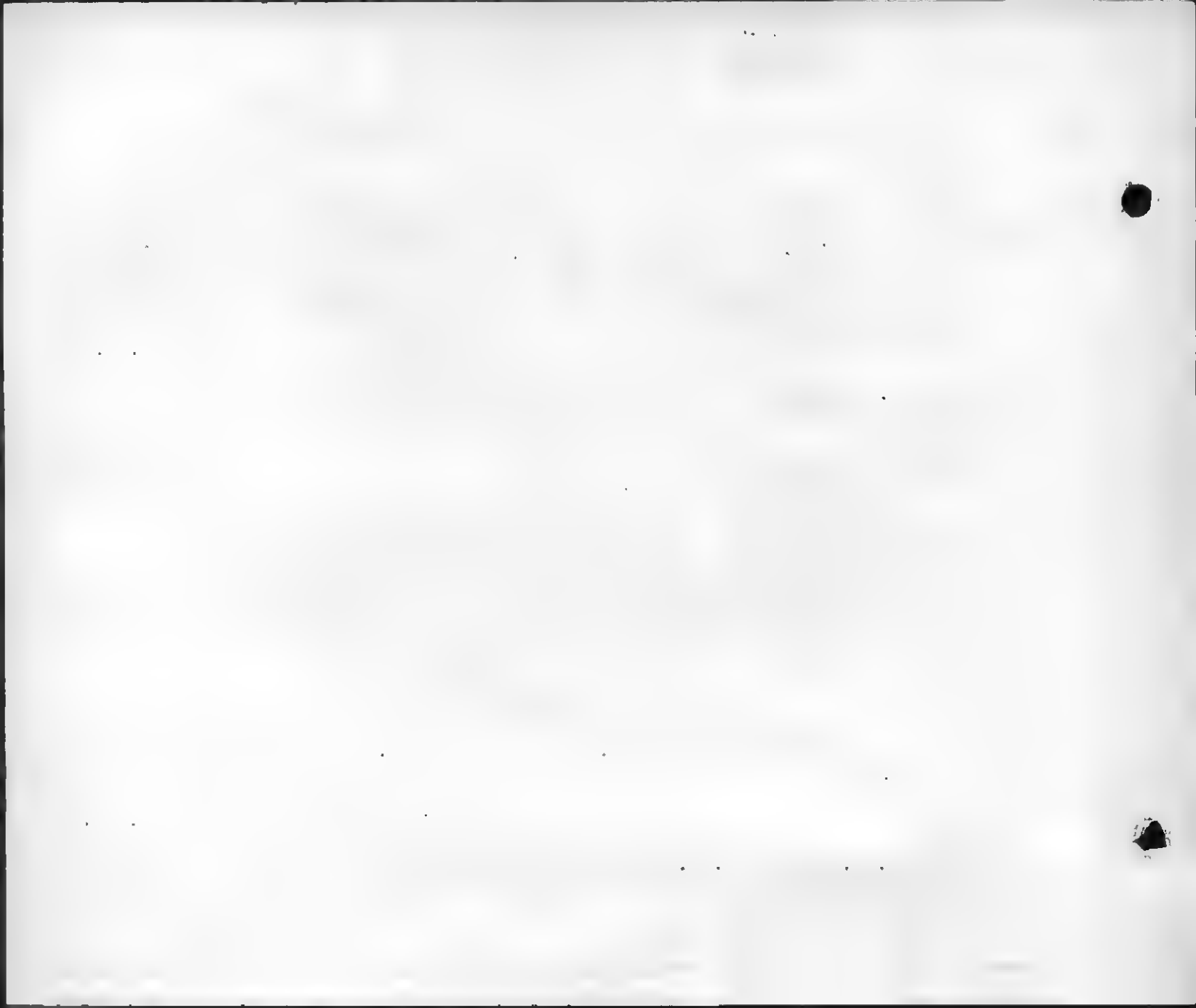
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14476

CERTIFICATE OF DEATH

Reg. Dist. No. 14478

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Cacapon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION Washington County		d. STREET ADDRESS c/o POSTMASTER	
3. NAME OF DECEASED (Type or print) First Middle Last Shirley Ann Whisner		4. DATE OF DEATH Month 12 Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months 8 Days 3 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harold D. Whisner		14. MOTHER'S MAIDEN NAME BETTY FARRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address HAROLD WHISNER, GREAT CACAPON, W.VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis; 13 1/2 hours 570.5 DUE TO (b) Perforated megacolon; indeterminate time Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Intestinal obstruction and ileus; 24 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 28th, 1960, to Dec. 5th, 1960, that I last saw the deceased alive on Dec. 5th, 1960, and that death occurred at 9:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE W. T. Layman M.D. Professional Arts Building Hags. Md. PHYSICIAN'S NAME (Type) W. T. Layman, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/60	
22c. NAME OF CEMETERY OR CREMATORY MT NEBO, CEM.		22d. LOCATION (City, town, or county) (State) GREAT CACAPON, W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE PARKS JOHNSON		24a. REC'D BY REGISTRAR DATE DEC 9 '60	
ADDRESS BERKELEY SPRINGS, W. VA.		24b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 14501 Item 2 File 62-8 1-3-61 et MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1447

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAHRNEY-KEEDY MEM HOME</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RIVINGTON New Windsor</u> d. STREET ADDRESS <u>407 Church Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>SALLY EDNA WILSON</u>		<b>4. DATE OF DEATH</b> <u>DEC. 23 1960</u>	
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>26 OCT. 1876</u>
<b>9. AGE</b> (In years last birthday) <u>84</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER - RETIRED</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>ADAMS CO. PENNA.</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>JESSE T. WILSON</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH (UNKNOWN)</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>HOME RECORDS, BIRNBAUM</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute decompensation of heart</u> <u>434.4</u> DUE TO (b) <u>Hypertensive arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>12 hours</u> <u>3 yrs</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. _____ 19____	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that I attended the deceased from</b> <u>October 18 1960</u> <b>to</b> <u>Dec 23 1960</u> <b>that I last saw the deceased alive on</b> <u>December 21 1960</u> <b>and that death occurred at</b> <u>7 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>ACTUAL SIGNATURE</b> <u>G. W. Hevan</u> <b>M.D.</b>		<b>ADDRESS</b> (Street, city or town, state) <u>Boonsboro Md.</u> <b>DATE SIGNED</b> <u>12/23/60</u>	
<b>PHYSICIAN'S NAME</b> (Type) <u>G. W. Hevan</u>		<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>26 DEC 60</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>SAMS CREEK</u> <b>22d. LOCATION</b> (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>D. D. Hartzler</u> <b>ADDRESS</b> <u>NEW WINDSOR MD</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DEC 27 '60</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14477

## CERTIFICATE OF DEATH

Reg. Dist. No. 14480

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2511 Maryland Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GOLDIE</u> Middle <u>N.</u> Last <u>Wolff</u>		4. DATE OF DEATH <u>Dec.</u> <u>25</u> <u>19 60</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13, 1931</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Superior Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>Kauffman Station, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James V. Wolff</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Diller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>214-32-4570</u>	
17. INFORMANT <u>Mrs. Wm Kline - Chambersburg, Pa.</u>		Address <u>RD 6</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Cor Pulmonale</u> <u>43 4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> (b) <u>Bronchopneumonia</u> lying cause lost. (c) <u>marked krypto-scoliosis &amp; lung compression</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>3 Days</u> <u>24 hrs?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept.</u> <u>19 59</u> to <u>Dec. 25</u> <u>19 60</u> that I last saw the deceased alive on <u>Dec. 25</u> <u>19 60</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John D. Turco</u> M.D.		ADDRESS (Street, city or town, state) <u>302 N. Potomac Street</u> DATE SIGNED <u>12-27-60</u>	
PHYSICIAN'S NAME (Type) <u>John D. Turco, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/29/60</u>		22b. DATE THEREOF <u>12/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>At. Munch - Greencastle, Pa.</u>		ADDRESS <u>Greencastle, Pa.</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

CERTIFICATE OF DEATH

1917

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John A. Smith		Male		45		Jan 15 1917		Boston, Mass.	
Cause of Death		Disease		Organ		Nature		Site	
Myocardial Infarction		Coronary Artery Disease		Heart		Narrowing of Arteries		Left Ventricle	
Duration of Illness		Previous Illnesses		Occupation		Habitual Habits		Social History	
3 weeks		Hypertension, Diabetes		Carpenter		Smoker, Drinker		Lived alone	
Medical History		Family History		Physician's Name		Physician's Address		Physician's Signature	
None		None		Dr. J. B. Brown		123 Main St.		[Signature]	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Place	
Cemetery		Jan 18 1917		10:00 AM		Cemetery		Cemetery	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Place	
Cemetery		Jan 18 1917		10:00 AM		Cemetery		Cemetery	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BARNHART 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14481

CERTIFICATE OF DEATH

14481

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>1 yr. 8 mos.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie L. Wray</u>				4. DATE OF DEATH Month Day Year <u>December 13 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 2, 1874</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Downsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
13. FATHER'S NAME <u>James Lambert</u>				14. MOTHER'S MAIDEN NAME <u>Jane Baldwin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>                    </u>			
17. INFORMANT <u>Mrs. Henry Tabler - Niece - Martinsburg,</u>				Address <u>                    </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>490X</u> IMMEDIATE CAUSE (a) <u>Labar pneumonia</u> DUE TO (b) <u>                    </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>                    </u> DUE TO (c) <u>                    </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>                    </u> 19 <u>                    </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>				20f. (City or town) (County) (State) <u>                    </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>11 Dec 1960</u> to <u>13 Dec 1960</u> , that (I) (we) last saw the deceased alive on <u>13 Dec 1960</u> and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Haak</u>				22b. DATE <u>13 Dec 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u>				22d. ADDRESS <u>Route 2 Williamsport, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-16-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Martinsburg, West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard B. Brown</u>				24a. REC'D BY REGISTRAR <u>                    </u> 24b. REGISTRAR'S SIGNATURE <u>                    </u>			
ADDRESS <u>Martinsburg, Md.</u>				DATE <u>DEC 16 '60</u>			

18-11